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**Large women's accounts of health and weight  
management in postpartum: a longitudinal qualitative  
study.**

**Suzanne Gertrude Connolly**

**Doctor of Philosophy  
University of Edinburgh  
2016**



## **Declaration**

I hereby declare that:

- This thesis has been composed solely by myself.
- The work presented within this thesis is my own.
- This work has not been submitted for any other degree or professional qualification.

Suzanne Connolly



“Ar scáth a chéile a mhaireann na daoine.”

*Irish Proverb*



## Abstract

Postpartum weight retention is commonly considered an important precursor to long-term weight gain, with existing research suggesting that failure to lose weight in postpartum has significant future health implications. While postpartum has been identified as a possible ‘window of opportunity’ for women to make health behaviour change and manage their weight, it remains unclear how mothers, and in particular ‘large’ ( $\text{BMI} \geq 40 \text{ kg/m}^2$ ) mothers, experience health and engage with health-related behaviours at this particular point in the life course. Existing research has done little to enhance our understandings of the lived, embodied and practical realities of caring for an infant and, crucially, how this impacts health and weight management during the postpartum period. In addition, qualitative research focusing on postpartum has largely ignored the temporal dimensions of this period and, instead, has tended to focus attentions on a single ‘snapshot’ in time.

To address these gaps in the literature, this study employed longitudinal qualitative methodology to explore 15 ‘large’ ( $\text{BMI} \geq 40 \text{ kg/m}^2$ ) women’s lived experience of health and weight management over the first six months following childbirth.

Participants were recruited from a specialist antenatal metabolic clinic based in Edinburgh, Scotland. When possible, three in-depth semi-structured interviews were carried out with each participant: the first at six weeks postpartum, the second at three months and, the third at six months postpartum. Both six weeks and six months have consistently been identified in the literature as important markers for postpartum women. Hence, it was hoped that by interviewing at these and an



intervening time point (i.e. three months) it would be possible to capture and understand processes of change with regards to weight management in the postpartum period.

The analysis revealed that accounts of health and weight were far from straightforward and seemed to be heavily influenced by the wider social context, which routinely pathologises, demonises and stigmatises ‘fatness’. Challenging contemporary discourses of the ‘obesity epidemic’ which frame the large body as a direct consequence of individual lifestyle, participants principally drew upon lay notions of inheritance and implicated a genetic predisposition to resist individual responsibility for weight and body size. The analysis suggests that concerns for health were largely predicated on subjective experiences and, in the absence of tangible and embodied experiences of ill-health, participants expressed little if any impetus to engage in weight management for the purpose of improving their health. In short, the idea that their weight was an indicator of poor health, or future health risk, was not a view shared by participants. Instead, they expressed more complex understandings of their weight, and their responsibilities to engage in health changing behaviour.

Despite articulating often strong desires to engage in weight management ‘for the baby’, the longitudinal focus revealed a disjuncture between these intentions and the reality of those engagements. Influential in this discordance was the transition from an intensely medicalised and closely monitored pregnancy, to a period of minimal or no follow up in postpartum. The lack of ‘surveillance’ appeared to have a notable impact on participants’ engagements with health-related behaviours once at home

and going about the day-to-day tasks of caring for their infant. Dominant discourses around ‘good’ mothering also made it difficult for participants to prioritise their own needs (such as weight management) ahead of those of their children and other family members. When participants reflected on their experiences of mothering they frequently drew upon understandings of themselves as relational beings and, at times, positioned themselves as phenomenologically inseparable from their baby. This relationality was often experienced as a diminishing of individual autonomy, as the body of the mother and the baby became inter-embodied and bounded.

Consequently, my analysis serves to problematise the individualised expectation surrounding a mother’s ability to act autonomously and engage in health-related behaviours in postpartum. These findings also call for a stronger appreciation to be developed of the complexities surrounding engagements with health-related behaviours at this particular point in the life course. In particular this research demonstrates the importance and utility of adopting a more embodied approach, which in turn has some notable implications for public health policy and practice.



## Lay Summary

In line with overall rising obesity levels, ever increasing numbers of women of reproductive age in the UK are either overweight or obese at the start of their pregnancy. When women become pregnant a substantial number tend to gain more weight than is recommended and often struggle to lose weight once the baby is born. This is particularly true for ‘large’ (clinically defined as morbidly obese<sup>1</sup>) women. The failure to lose weight gained in pregnancy has notable short and long-term health implications for both women and their children. Increasingly, the period following childbirth has been identified as a possible ‘window of opportunity’ to intervene and encourage women to make lifestyle changes. However, we know very little about the perceptions and experiences of large women regarding their bodies, health and weight management at this particular point in their lives or about the kinds of support and information which might be useful to women when trying to manage their weight.

In an attempt to address this problem, 15 large women who had attended a specialist antenatal metabolic clinic which provides tailored care to pregnant women with a BMI  $\geq 40 \text{ kg/m}^2$ , were interviewed on three separate occasions in the first six months following childbirth. They were asked to talk about their daily lives with their infant, their health, how they felt about their body size and weight, their eating and physical activity practices and their experiences of weight management during this time.

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<sup>1</sup> Morbidly obesity is defined as having a BMI  $\geq 40 \text{ kg/m}^2$ . For example, a woman who is 5'7" and weighs approximately 280 lbs. would have a BMI of approximately 43.8  $\text{kg/m}^2$ .

The study findings show that the ways in which large women view their health and weight is far from straightforward. Contrary to popular medical opinion about the causes of obesity, most of the women interviewed felt like they had very little control over their body weight and size. Although aware of the risks of obesity to their long-term health, most women did not feel like their weight was currently impacting on their health and, therefore, were not typically motivated by health reasons to lose weight. Furthermore, even though women expressed feeling highly motivated to manage their weight ‘for the baby’ during this time, in reality their intentions rarely materialized. Women suggested that their struggle to manage their weight could be attributed to a number of reasons. To begin with the findings suggest that, in the absence of support from the specialist clinic, and once at home and consumed by the day-to-day tasks of caring for their infant and other family members, that it was difficult for women to prioritise their own needs. In fact most of the women in this study suggested that sacrificing their own needs (and health) was part and parcel of being a ‘good’ mother. In particular women suggested that they felt a diminished sense of independence and autonomy and that their bodies had essentially become tied to the highly dependent body of the baby. The interconnected nature of this relationship presented significant practical challenges to their ability to prepare healthy meals and pursue physical activities outside of the home.

These findings call for a stronger appreciation to be developed of the kinds of complexities surrounding engagements with health-related behaviours at this particular point in the life course. In particular, this research demonstrates the importance of looking at how the bodies of others (particularly the dependent body of the baby) interacts with, and, affects the mother’s ability to act independently. In

turn this has some notable implications for public health policy and practice and for the kinds of interventions and support that are likely to be most successful in helping and encouraging women to manage their weight following childbirth.

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## List of abbreviations used

AMA	American Medical Association
BMI	Body Mass Index
CDC	The Centers for Disease Control
CMACE	Centre for Maternal and Child Enquiries
ESRC	Economic and Social Research Council
GDM	Gestational Diabetes Mellitus
HAES	Health at Every Size
HBM	Health Belief Model
HWA	Healthy Weight Advisor
IOM	Institute of Medicine
MAEYS	Maternal and Early Years Health Weight Service
MRC	Medical Research Council
NHS	National Health Service
NOO	National Obesity Observatory
NICE	National Institute for Health and Care Excellence
OECD	Organization for Economic Co-operation and Development
RCOG	The Royal College of Obstetricians and Gynecologists
SIMD	The Scottish Index of Multiple Deprivation
WHO	World Health Organization





## Chapter 1: Introduction

Obesity is rising in an exponential manner in the UK, with Scotland playing host to one the worst obesity records among developed countries (Scottish Health Survey, 2014). Obesity has been identified as a major risk factor for several chronic diseases including, but not limited to; cardiovascular disease, type 2 diabetes, hypertension and certain cancers (World Health Organization (WHO), 2015), and consequently, there has been an increased emphasis on finding solutions to this problem.

Moreover, in recent years, there has been an increasing public health focus directed towards the exploration of maternal obesity, as there is considerable cause for concern regarding the short and long-term health implications for the mother and subsequent generations (Sebire et al., 2001; Andreasen et al., 2004; Heslehurst, 2011c; Lewis, 2011). Postpartum weight retention is commonly considered an important precursor to long-term weight gain, with existing research suggesting that failure to lose weight in postpartum has significant future health implications (Gunderson et al., 2001; Davis et al., 2009; Endres et al., 2014). A salient feature of much of the research is the assertion that the postpartum period is a ripe time for intervention (Peterson et al., 2002; Krummel, 2007; Evenson et al., 2009), a time when women are in contact with health professionals and, therefore, a captive audience for health promotion messages (Ohlendorf, 2012). Postpartum has also been endorsed as a period when women may be more receptive to advice regarding health-rated behaviour as they are eager to create a healthful environment for their new-born and, accordingly, are more responsive to health-behaviour change (Stapleton et al., 2009).

Despite the frequency with which this assertion is reproduced in the literature, there is little evidence to suggest this is the case and it remains unclear how mothers, and in particular ‘large’<sup>2</sup> mothers, experience health and engage with health-related behaviours at this particular point in the life course. Few, if any, studies can confirm that health interventions in postpartum are successful either in the short or long-term (Walker et al., 2004a). Furthermore, most of the studies are US based and the UK context is potentially quite different. There are limited guidelines for behaviour modification for women in the postpartum period and, where there are, the focus tends to be on individual behaviour modification and short-term, ineffectual interventions. Warin et al. (2008) posit that “despite advances in understanding the physiology and psychology of obesity, prevention and intervention programmes continue to fail” and that there is little research which demonstrates the effectiveness of postpartum lifestyle interventions (2008: 98). Aphramor (2005) echoes this view, suggesting that the promotion of weight loss “fails to integrate people’s lived experience as gendered, situated bodies in an inequitable world” (2005: 315).

In addition, qualitative research focusing on postpartum has largely ignored the temporal dimensions of this period and, instead, has tended to focus attention on a single ‘snapshot’ in time. There is a dearth of qualitative, longitudinal research exploring large women’s experiences of their bodies and perceptions of weight in postpartum (Carter-Edwards et al., 2009), willingness and ability to diet and be physically active to lose weight, and, few studies that explore the experiences of obese populations. As obesity amongst women of reproductive age becomes more

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<sup>2</sup> The use of this term will be explained in more detail in section 1.2.1 below.

prevalent (Kanagalingam et al., 2005; Heslehurst et al., 2007; Scottish Health Survey, 2014), there is a need to gain an understanding of the embodied experiences and the meaning and constructions of health, attitudes towards health, and engagements with health-related behaviours in the lives of large women at various points over the postpartum period. Is there, for example, an ideal time during postpartum to begin health interventions? Understanding attitudes towards the body and health-related behaviours and how, and why, these attitudes may change and adapt over the postpartum period, and the impact and role of a host of contextual factors, is pivotal if we can begin to tailor and target suitable and successful health initiatives.

## **1.2 A note on terminology**

There are a number of key terms which I employ throughout this thesis which are noteworthy and necessitate that I offer some justification and rationale for their use. The most significant of these are detailed in sections 1.2.1 and 1.2.2 below.

### **1.2.1 Why use the term ‘large’?**

The term ‘large’ within the context of this thesis refers to a BMI  $\geq 40$  kg/m<sup>2</sup> and in a clinical sense, refers to a designation of ‘morbid obesity’. However, I have very purposely elected to use this particular term (over others) as it reflects one of the most common descriptors employed by my participants when talking about their weight. By using words such as ‘large’ and ‘fat’ I also attempt to acknowledge the socially constructed nature of ‘fatness’ (see Kulick and Meneley, 2005) and the extensive body of work which has highlighted the negative associations with terms like ‘obesity’ (see Campos et al., 2006; Cohen et al., 2005; Gard and Wright, 2005).

Finally, when I have used of the term ‘obese’ in this thesis I do so when referring to medical understandings of the term and to reflect its use and prevalence in the existing literature. As a result, in Chapter 2, I predominantly use the term obese when discussing the work of others and in later chapters I primarily use the term large.

### **1.2.2 Defining the postpartum period**

Postpartum refers to the period following childbirth. There is however a lack of consensus in the literature regarding the length of this period. For example, The WHO (1998) defines the postpartum period as beginning one hour after the delivery of the placenta and continuing until six weeks (42 days) after the birth of the infant. Clinical literature has suggested that physiologically speaking a woman’s body does not fully return to its pre-pregnant physiology until about six months post-delivery (Romano et al., 2010). Moreover, research in the area of weight management has been far less consistent in its use of the term postpartum, but most commonly refers to a period of time up to a year following childbirth. However, for the purposes of this study and based on my review of the available evidence, it seemed reasonable to define postpartum as the six month period following childbirth.

### **1.3 Outline of the thesis**

In this introductory chapter I have offered a brief summary and some necessary background to this study. I have also briefly discussed some of the issues associated with the use of certain terms related to obesity and postpartum and have clarified my decision (and the meanings intended) when using particular terminology in this thesis. In the following I provide an overview of the chapters that comprise the remainder of the thesis.

Chapter 2 provides an overview of the key literatures pertaining to maternal obesity and the postpartum period. In doing so, I identify some of the notable gaps in the existing literature and provide an informed and strong rationale for the proposed study. Maternal obesity, particularly the underexplored area of postpartum, touches on many literatures and discourses. Hence, my reading has allowed me to cast a wide net, to encompass: Feminist/gender scholarship, health and obesity discourse, mothering, and the body and social theory, and, accordingly a diversity of literatures are reflected in this review. The review of literature in particular draws attention to the dearth of scholarship exploring the temporal dimensions of the period and forms a convincing justification for my decision to adopt a longitudinal approach. The chapter culminates with my research aims and research questions.

Chapter 3 details the research methodology used in this study and highlights the philosophical and theoretical influences which have both informed and shaped my research practice. In this chapter I also discuss some of the key ethical considerations, sampling and recruitment of the study participants. I then discuss my analysis and, in doing so, highlight some of the practical challenges I encountered when attempting to analyse the data. I conclude by reflecting on some of the unique issues which arose when attempting to explore topics related to embodiment/body with my participants and, finally, I reflect on some of the practical difficulties I encountered when conducting interviews with women in the presence of small children.

Following Chapter 3, I present a short descriptive vignette of one of the study participants, ‘Susan’. The vignette has been included with a view to contextualising

the findings chapters and introducing certain shared themes which are threaded across the majority of accounts. The vignette is intended to offer the reader the opportunity to move closer to participants' accounts and to offer a more comprehensive picture of the interview environment.

Chapter 4 is the first of four findings chapters presented here. This chapter explores the ways in which my participants spoke about and understood their 'fat' bodies in day-to-day contexts. The analysis showed that how the women in my study made sense of and spoke about their body weight and size could only be understood when framed against a wider social context, which routinely pathologises, demonises and stigmatises 'fatness'. In this chapter I also explore how participants explained and rationalised their body size and weight by drawing on lay notions of inheritance, and I argue that by doing so, these women seemed to be resisting notions of individual responsibility for body weight and size. In later chapters I will continue to demonstrate the saliency of some of the themes raised in this chapter and their significance to women's understandings of health and their engagements with health-related behaviours. As such, the analysis presented in this chapter should not be seen as confined or restricted to a discrete chapter but, rather, a dialogue building upon itself as this thesis progresses.

Chapter 5 is the second of the findings chapters presented and focuses on how these women described experiencing and conceptualising their health. The analysis suggests that concerns for health were principally 'present orientated' rather than 'future orientated' and were largely predicated on subjective experiences of ill-health. Moreover, there was little engagement with notions of risk. My analysis

revealed that, in the absence of tangible and embodied experiences of ill-health, participants expressed little if any impetus to engage in weight management for the purpose of improving their health. Understanding how these women conceptualised and experienced their own health as large women informs aspects of the upcoming chapters, which (in part) explore participants' experiences of weight management.

Chapters 6 and 7 are closely related as both address aspects of weight management. Chapter 6 focuses predominately on key aspects of participants' accounts of historical weight management and their experiences of weight management during their most recent pregnancy, as they attended a specialist antenatal metabolic clinic. In particular, I focus on notions of control which formed a central feature of their accounts. This chapter forms an important precursor to some of the findings presented in Chapter 7.

Chapter 7 is the final of the findings chapters and explores participant accounts of their engagements with weight management and certain health related behaviours during the postpartum period. It should be emphasised that the analysis presented here has been informed and contextualised by the preceding three findings chapters. The chapter begins by exploring participants' intentions to engage in weight management and aspirations to make health-behaviour change during the postpartum period. My analysis revealed that despite articulating often strong desires to engage in weight management, those intentions rarely materialised in reality. I also identify a number of factors which seemed significant in explicating this discordance between intentions to engage in certain health-related behaviours and the reality of those engagements. Participant accounts suggested that the transition from the intensely



medicalised and closely monitored period of pregnancy had a notable impact on their engagements with health-related behaviours once at home and going about the day-to-day tasks of caring for their infant. Drawing on notions of inter-embodiment<sup>3</sup>, my analysis suggests that the most significant factor impacting on participants' engagements with health related behaviours during this period could be accounted for by their inter-embodied relationship with their baby and perceptions about their ability to act autonomously and independently of the baby.

The final chapter (Chapter 8) brings together the key themes and issues raised in the preceding findings chapters. These are discussed within the context of the existing literature. In particular, I suggest that this study has demonstrated the importance and utility of exploring the postpartum period through an inter-embodied lens.

Furthermore, I note that such an approach facilitates a stronger appreciation of the complexities surrounding engagements with health-related behaviours at this particular point in the life course. Finally this thesis concludes with a discussion of the study limitations, and some of the key implications for policy, practice and avenues for future research.

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<sup>3</sup> The concept of inter-embodiment refers to the notion that knowledge and self-identity are constructed through our embodied interaction with other bodies. This will be unpacked and discussed more conceptually in Chapter 8.

## Chapter 2: Review of literature

### 2.1 Introduction

This chapter sets the stage for understanding the importance of research exploring large women's experiences of health and weight management following childbirth. In the following I offer a selective review of literatures with the intention of highlighting some of the key issues and notable gaps in existing scholarship and, in doing so, give an informed and strong rationale for why I elected to undertake this research project.

Maternal obesity, particularly the underexplored area of postpartum, touches on work from several academic disciplines and discourses. Hence, this review reflects the cross-cutting nature of my study and casts a wide net, to encompass: biomedical literatures, feminist/gender scholarship, health and obesity discourse, mothering, and the body and social theory. It should be noted that although this is a study which focuses on postpartum, this review also incorporates an extensive discussion of pregnancy. I felt this was an important and necessary step in order to adequately contextualise some of the later discussion around postpartum. Some of the work presented here will be revisited and critically examined in later chapters. However, as the nature of qualitative research is explorative and heuristic, my analysis and interpretation of the findings demanded that I draw from a host of other literatures and theoretical concepts not identified at the outset. As such those literatures will be presented and unpacked *in situ* in subsequent chapters. My later engagement with these literatures is also in large part reflective of my own academic evolution in the process of conducting this research.

For the purposes of clarity, this chapter is broadly divided into two sections. In the first section I am largely concerned with presenting an overview of the existing biomedical research in the area of maternal obesity. This section begins with an overview of the search strategy and follows with a brief summary of obesity trends worldwide. I then go on to address maternal obesity, specifically focusing on the issue of weight retention in postpartum. Following on from this, I discuss the existing qualitative research looking at weight management in postpartum. The second section of the chapter offers an overview of some of the ways in which the body and notions of embodiment; specifically, the postpartum body have been interpreted, understood and positioned in the existing sociological and feminist literatures. I discuss these in order to highlight the importance and centrality of the body to this project but also to underscore the neglect of ‘lived’ and embodied experiences in the current research looking at weight management in postpartum. The chapter concludes with my research aims and questions.

## **2.2 Search strategy**

As highlighted previously, this review draws on literature and theoretical concepts from a host of academic disciplines and as such, it required a varied and dynamic approach to the review of literature. In the first instance, I carried out a systematic search using a number of databases to identify relevant qualitative and quantitative research looking broadly at weight management in postpartum. Although the quantitative research served to contextualise my research more broadly speaking, as the focus of this research was on the subjective experience of weight management, a much stronger emphasis was placed on qualitative studies. This aspect of my search

encompassed databases including OVID Medline, ASSIA, Cochrane Review and Web of Knowledge. I also searched and read widely across several areas of theoretical interest, in particular from the sociological literatures. In this instance, literature was typically identified using snowballing techniques and was indispensable for helping to identify other authors, theories and concepts.

As touched upon previously, the review of literature was not a discrete aspect of the research process but an inductive and ongoing process and continued for the duration of the research project. For example, as my research progressed and particular themes emerged from the data, additional searches of the literature were undertaken and incorporated into the findings and discussion chapters.

### **2.3 Obesity: An overview**

Obesity is defined by the WHO as an accumulation of excess body fat that adversely affects one's health (WHO, 2015a). Over the past two decades there has been a steady rise in the prevalence of overweight and obesity<sup>4</sup>, which is now said to constitute a global 'epidemic' and is considered one of the most significant challenges in the 21<sup>st</sup> century. Scotland has one of the worst obesity records in the developed world, and one of the highest rates of all Organization for Economic Co-operation and Development (OECD) member countries and European countries (WHO, 2012b). In a recent report, the Scottish Government stated that should current trends continue, that by 2030 adult obesity in Scotland could reach over 40%. Even

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<sup>4</sup> There is now some evidence to suggest that obesity levels may be leveling off. However, recent research has suggested that such assertions are tenuous (see Visscher et al., 2015).

with current health improvement efforts, this is an increase of more than 50% over 2008 levels (The Scottish Health Survey, 2014).

In the biomedical literature, obesity has long been acknowledged as a ‘risk factor’<sup>5</sup> for poor or diminished health and is associated with higher rates of morbidity and mortality. For example, it is purported that obese individuals are particularly susceptible to a number of chronic diseases; such as, cardiovascular disease, type 2 diabetes, hypertension and certain cancers (WHO, 2015a). In addition, being obese is linked with increased risk of depression and anxiety, and decreased quality of life (Garipey et al., 2010). Many obese individuals, for example, experience social stigmatisation against a broader medical and cultural backdrop which frames ‘fat’ and obesity in very negative ways. Puhl and Heuer (2009) in an systematic review of decades of largely US based research documenting bias and stigma towards overweight and obese persons, suggest that weight bias is persistent in settings of employment, health care, education, the media and in close interpersonal relationships with family members and romantic partners. The authors suggest that weight bias and stigma pose significant “threats to emotional and physical health of obese individuals” and report that, despite the increase in the prevalence of obesity, that this does not appear to have “attenuated negative societal attitudes towards obese people” (Puhl and Heuer, 2009: 960). In addition, the high rates of obesity and associated health risks not only have implications for the quality of life of individuals, but have placed substantial demands on already stretched health services (Wang et al., 2011). By some estimates it is predicted that by 2030 obesity related

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<sup>5</sup> I also recognise that obesity is now categorised as a disease in its own right in the US (see American Medical Association (AMA), 2013).

diseases will add in the region of an additional £1.9-2 billion per year in medical costs to the National Health Service (NHS) (Wang et al., 2011).

### 2.3.1 Measuring obesity

Obesity is most commonly measured using body mass index (BMI). BMI is a simple index of weight-for-height and is expressed as an individual's weight in kilograms (kg) divided by their height in meters squared ( $m^2$ ). A BMI which falls within 18.5 to 24.9 ( $kg/m^2$ ) is considered a desirable and 'normal' weight. A BMI of 25 to 29.9 ( $kg/m^2$ ) is considered 'overweight' and a BMI over and above that is considered 'obese' (WHO, 2015b). Amongst those who are categorised as obese the WHO (2015b) has made further distinctions within this category, which are represented in Table 1 below:

**Table 1: BMI Classification for Obesity**

BMI	Classification
BMI 30-34.9 ( $kg/m^2$ )	Class I obesity
BMI 35-39.9 ( $kg/m^2$ )	Class II or severe obesity
BMI $\geq 40$ ( $kg/m^2$ )	Class III or morbid obesity

Although BMI is extensively used to 'diagnose' obesity and provides an inexpensive supposedly reliable measure of weight, it has also been problematised in both the biomedical and sociological literature. For example, in the clinical literature it has been criticised as it assumes independence of factors such as age, gender, levels of

physical activity, and race or ethnicity, which are known to influence body mass (Gallagher et al., 1996; Williams et al., 2015). Moreover, although both increases in both body fat and lean tissue cause increments in BMI, as a measure it fails to differentiate between the two, resulting in very lean individuals, such as athletes being miscategorised as obese (Rothman, 2008).

At the same time, much of the criticisms in the sociological literature centres around the efficaciousness of using such a ‘crude’ measure of adiposity to determine health status (see Bacon and Aphramor, 2011; Campos, 2004; Monaghan, 2007; Rich and Evans, 2005), particularly its utility at the level of the individual (National Obesity Observatory (NOO), 2014). Such work has not only highlighted the ad hoc and indiscriminate nature of the cut-off points at which one ‘becomes’ obese, it has also laid challenge to the ubiquitous claims made in the biomedical sciences which uncritically position ‘fat’ as unhealthy (Evans and Colls, 2009; Guthman and DuPuis, 2006). It has been argued that this uncritical application of the BMI reinforces the notion that obesity can be understood as an uncomplicated biomedical category or disease and, hence, obscure its socially constructed (and highly contested) nature (see Boero, 2007; Campos et al., 2006; Gard and Wright, 2005). Moreover, Evan and Colls (2009) have argued that the BMI fails to accurately reflect individuals’ embodied experiences of health. Despite these debates around the rather inexact, inappropriate and indiscriminate nature of BMI, it nevertheless continues to be one of the most widely used methods for assessing body composition and health status.

### **2.3.2 The causes of obesity**

The causes of obesity are considered to be complex and the result of numerous overlapping individual, behavioural, environmental and structural factors. According to Maddox and Liederman (1969), the obese person represents a “complex mixture of medical fact and socio-cultural values” (1969: 13). Current research on obesity aetiology in the general population increasingly positions environmental and social factors as fundamental in the exponential rise of obesity (Kumanyika et al., 2002; Swinburn et al., 1999 ). Potential socio-cultural determinants of obesity include not only social circumstances, such as economic and material wealth (Forde and Raine, 2008), but also social norms regarding body weight, physical activity and eating, levels of social support for obesity-protective behaviours, social capital, social and cultural customs, values or expectations regarding what is important in relation to the role of food, or, for example, the acceptability of physical activity/exercise (Ball and Crawford, 2006). Of these, it is noteworthy that strong associations have been documented between the prevalence of obesity and socioeconomic status, with overall prevalence increasing with level of deprivation – this is particularly true for women (NOO, 2014).

These debates notwithstanding, the exponential rise in obesity has for the most part been attributed to dramatic changes to lifestyles, such as the unprecedented prevalence and accessibility of cheap, high calorie foods as well as sedentary behaviours. Moreover, despite the multitude of discourses surrounding obesity aetiology (some of which have been addressed above), the most pervasive of these emphasises individual responsibility and is premised on the notion that obesity is



caused by an overconsumption of calories, which exceeds expenditure (WHO, 2015a). For example, the NHS (2014) factsheet on the causes of obesity begins by stating that “obesity is generally caused by eating too much and moving too little” (2014: para. 1). These types of assertions reflect a broader neoliberal approach to health and one which places responsibility for weight management firmly with the individual (Guthman and DuPuis, 2006). I discuss the implications of approaches to health which are premised on the notion of individual responsibility a little later in this review.

## **2.4 Maternal obesity**

Not surprisingly, commensurate with overall rising obesity levels are ever increasing numbers of women of reproductive age in the UK who are either overweight (BMI 25-29.9 kg/m<sup>2</sup>) or obese (BMI  $\geq 30$  kg/m<sup>2</sup>) at the start of their pregnancy (Heslehurst et al., 2007b; Kanagalingam et al., 2005; Scottish Health Survey, 2014). The increase in obesity amongst women of childbearing ages in the UK has been described as one of the most significant challenges facing maternity services today (CMACE, 2010). Denison and Chiswick (2011) report that obesity is now one of the most common antenatal co-morbidities, affecting one in five pregnant women in the UK. The UK prevalence rate of women with a BMI  $\geq 40$  at any time during pregnancy is approximately 2% (CMACE, 2010; Fitzsimons and Modder, 2010; Heslehurst et al., 2007, 2010). In line with the exponential rise of obesity among women of reproductive age, maternal obesity has increasingly become the focus on attention, in recognition of both short and long-term health implications for the mother and subsequent generations (Andreasen et al., 2004; Denison et al., 2015;

Lewis, 2011; Sebire et al., 2001). There is growing evidence, for example, that being obese prior to conception, during pregnancy and postpartum can have significant short and long-term health implications for the mother and also the child. Moreover, increasing numbers of clinical studies have focused on the risks associated with ‘excess’ gestational weight gain<sup>6</sup>, reporting that overweight and obese women are far more likely to experience ‘excessive’ weight gain during pregnancy than women of ‘normal’ weight (Rasmussen and Yatkin, 2009; Restall et al., 2014).

Maternal obesity and excessive weight gain during pregnancy are associated with a number of complications for the mother; such as, caesarean delivery, macrosomia, gestational hypertension, preeclampsia, gestational diabetes mellitus (GDM)<sup>7</sup> (Doherty et al., 2006; Heslehurst et al., 2008). Jarvie and Ramsay (2010) suggest that there is in fact a correlation between risk of pregnancy complications and the degree of obesity, with the level of overall risk increasing in a linear fashion with increases in BMI. Research has also suggested that obesity in the mother has notable implications for the child which include increased risk of foetal death, possible birth defects and low breastfeeding rates (Aune et al., 2014; Stothard et al., 2009; Turcksin et al., 2014). Furthermore, there is now considerable evidence to suggest that maternal obesity and excessive gestational weight gain are independently associated with greater risk of type 2 diabetes (Poston and Patel, 2014; Torloni et al., 2009) and the development of obesity among children (Walters and Taylor, 2009).

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<sup>6</sup> Gestational weight gain refers to the amount of weight gained from conception to delivery. In practice when gestational weight gain is calculated, it is from the weight recorded at the first antenatal booking appointment (which is typically at 10-12 weeks in the UK). This is considered accepted practice as there is typically minimal weight gain in the first trimester (Heslehurst et al., 2011b).

<sup>7</sup> Carbohydrate intolerance of varying severity, which is diagnosed in pregnancy and may or may not resolve after pregnancy.

There are also significant resource implications arising from the management of complex pregnancies - as noted earlier obese women in the UK are more likely to have caesarean sections (Heslehurst et al., 2008) and also tend to have longer hospital stays as well as being more likely to experience complications, such as infections in postpartum (Heslehurst et al., 2008). Not surprisingly, these types of medical interventions are also associated with additional costs for health services (Denison et al., 2015; Morgan et al., 2014).

#### **2.4.1 Guidelines for weight management in pregnancy for obese women**

In response to the increased awareness of the health effects of maternal obesity and a growing interest and need to address these issues, two sets of guidelines<sup>8</sup> specifically looking at the clinical management of maternal obesity and weight management for obese women during pregnancy and postpartum, were published in the UK in 2010. Despite the existence of these guidelines a pervasive knowledge gap exists between health care providers and obese women who are either contemplating pregnancy, in pregnancy, or in the postpartum period. Furber and colleagues (2013) suggest that these gaps are first and foremost exacerbated by the limited, ambiguous, if not “contentious” nature of the existing guidelines (2013: 3). The current guidelines for obese women in pregnancy, for example, recommend that these women restrict their weight gain from between 5 kg and 9.1 kg<sup>9</sup>. However, Furber and colleagues (2013) argue that these recommendations are highly problematic as they have been made

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<sup>8</sup> CMACE/RCOG (2010) joint guideline ‘Management of women with obesity in pregnancy’ and NICE (2010) ‘Weight management before, during and after pregnancy’.

<sup>9</sup> As a point of comparison, the guidelines recommend that women categorised as ‘low’ to ‘normal’ weight, gain between 11.5kg to 18 kg during pregnancy.

despite the lack of “robust evidence about optimal weight management in pregnancy for obese women” (2013: 2; see also Heslehurst et al., 2011a). For example, it remains unclear as to the effects of weight loss in pregnancy and although women are not advised to diet *per se*, a number of studies have reported that obese women often lose weight in pregnancy, but there is little understanding as to why this might be the case. One of these studies, a retrospective review of pregnancy outcomes in the US found that 11% of obese women lost or maintained weight in pregnancy, compared to 0.1% of ‘normal’ weight women (Edwards, 1996). More recent published studies have mirrored these findings and have also noted that the incidence of weight loss in pregnancy tends to increase as BMI increases (Bodnar, 2010; Hinkle, 2010).

Furthermore, according to the existing guidelines it is recommended that obese women be informed of the risks associated with excess weight (both the risks posed to themselves and to the foetus) in pregnancy and encouraged to eat healthily and be physically active to prevent excessive weight gain. However, Keenan et al. (2010) argue that this results in a precarious situation, as there is little, if anything, that a woman can ‘do’ (outside of traditional recommendations to eat healthily and be physically active) to reduce risk.

Recent studies have also explored women’s awareness of the risks associated with maternal obesity and the complex and multifaceted nature of their engagements with health care providers. These studies, which are considered further below, illuminate yet other dimensions and complexities in this area of research.

#### **2.4.2 Risk awareness among obese women**

Given the lack of guidance around the issue of maternal weight management for obese women, it is perhaps not surprising to find that women are largely unaware of the risks of obesity in pregnancy. Moreover, the lack of guidelines and training around how best to address the subject of maternal obesity have also been identified as a barrier to consistent practice amongst health care professionals in the UK (Heslehurst et al., 2010; Heslehurst et al., 2014) and tend to rely on the knowledge and comfort level of the midwife regarding issues of diet and weight management. A number of qualitative studies based in the US have also raised concerns around the failure of health care practitioners to adequately address weight management among obese women who are either pregnant or in postpartum. For example, Stengel, et al. (2012) in a qualitative study looking at overweight and obese women's experiences of gestational weight gain after the birth of their first child, reported that based on their respondents' accounts, advice on gestational weight gain was often insufficient, inappropriate and therefore unlikely to positively influence health-related behaviours. In another study, Phelan et al. (2011) reported that less than half of the study participants indicated that they had received advice from a pre-natal provider about recommended amounts of weight gain during pregnancy. The researchers also point out that "younger, economically disadvantaged women and those with a previous pregnancy were less likely to report receiving practitioner advice about weight gain" (Phelan et al., 2011: 588). In a qualitative study which looked at obese women's perceptions of obesity as a risk factor in pregnancy and their experiences of NHS maternity care, Keely et al. (2011) reported that women did not feel that risks of being obese and associated complications had been adequately explained to

them. Similarly, in another UK based study Smith and Lavendar (2011) found that a lack of information from health professionals about the health risks associated obesity in pregnancy had led their participants to think that maternal obesity was ‘acceptable’. They also reported that, when risk was communicated to their participants, it was often viewed negatively and evoked strong feelings of guilt. It should be borne in mind that those negative experiences and feelings of guilt could have an undesirable, trickle-down effect, which may impact on future health behavior interventions by health providers.

This is a situation which has been reflected in the findings of other studies which have explored the experiences of obese patients in the general population. For example, a number of UK studies have reported that overweight and obese individuals often perceive health care providers as ambivalent, insulting, demeaning, discriminating, judgmental, blame-inducing, highly insensitive, patronising and derogatory (Brown et al., 2006; Keenan and Stapleton, 2010). Indeed, other research has suggested that interactions with health care providers may achieve the opposite effect of “hardening and disenfranchising women” (Keenan and Stapleton, 2010: 381). Consequently, patients often avoid seeking and returning to health care settings in light of negative experiences (Brown et al., 2006; Merrill and Grassley, 2008).

Health care providers also report a number of barriers to discussions of obesity and risk and have suggested that the sensitive nature of obesity discussions acts as a barrier to broaching the topic (Heslehurst et al., 2010; Heslehurst et al., 2015; Heslehurst and Russell, 2011; Oteng-Ntim et al., 2010). Heslehurst et al. (2011c) suggests that the “psychosocial relationship with weight for many women makes the

message that ‘obesity may increase pregnancy risks’ a largely unwelcome one” (2011c: 162). They further argue that how this issue is approached and managed by healthcare professionals is “critical” (2011c: 162).

The lack of awareness of obesity risk among women may also have potential carry-over effects into postpartum. For example, in a Scottish study looking at the beliefs of overweight and obese pregnant women regarding physical activity in pregnancy, Weir and colleagues (2010) reported that the majority of their participants were “unconcerned about weight gain during pregnancy” and “tended to defer any intention to address pregnancy-related weight gain to the postnatal period” (2010: 5; see also Olander et al., 2011). How this lack of concern for weight gain in pregnancy impacts the postpartum period has yet to be explored.

## **2.5 The significance of weight retention in postpartum**

Apart from the risks associated with maternal obesity and excessive gestational weight gain in pregnancy, crucial for many women is that pregnancy, or rather the failure to lose weight gained in the period immediately following childbirth, can become the starting point and catalyst for future and life-long development of overweight and obesity (Gunderson, 2009; Oken, 2007; Walker et al., 2004b). Moreover, studies have stressed the importance of the first year postpartum as a pivotal point for weight gain (Amorim et al., 2007; Endres et al., 2015; Rooney et al., 2005). Endres et al. (2015) in a recent observational study which looked at risk factors for postpartum weight retention one year after delivery, among 774 predominantly low income women in the US, found that approximately 75% of women were heavier at one year postpartum than they were pre-pregnancy. These

findings included 47.4% of women who retained more than 10lbs and 24.2% who had retained more than 20lbs. Other observational studies have explored the long-term implications of pregnancy weight retention. For example, in their seminal study, Rooney and Schauburger (2002) looked at the impact of excess pregnancy weight gain and failure to lose weight by six months postpartum on excess weight eight to ten years later. This study reported that women who were able to lose the weight they gained during pregnancy were only 2.4 kg heavier at long-term follow-up, in comparison to women who had retained weight by six months postpartum. On average the women who retained weight tended to be 8.3 kg heavier at long-term follow-up. In a follow-up study, Rooney et al. (2005) reported that by 15 years following childbirth, the women who had retained weight postpartum were now at risk of obesity and were more prone to developing heart disease and other chronic obesity-related diseases. Of particular interest in this study is the assertion that women who are overweight or obese at conception had the greatest risk of retaining weight at one year postpartum, which it has been suggested further encourages the development of obesity (see also Davis et al., 2009; Gunderson et al., 2009).

There are significant implications for women who fail to lose weight between pregnancies and who, therefore, increase their risk for all future pregnancies (Villamor et al., 2006). For many women the postpartum period is also the pre-conceptual period for their next baby. Bobrow et al. (2009) who conducted a cross-sectional analysis within a large prospective study, looking at the relationship between childbearing and breastfeeding and subsequent body mass index (BMI) in middle-aged women, found that BMI increased significantly in women following the birth of each subsequent child.



Consequently, we must consider pregnancy and postpartum as being inextricably bound together and the role of weight management in postpartum as having heightened importance. Gaining an understanding of the realities of life after childbirth could help to inform appropriate and effective kinds of health behaviour interventions that both encourage and support the development and maintenance of healthy lifestyles in mothers and subsequent generations.

## **2.6 A ‘window of opportunity’?**

Perhaps in part because of the long-term implications of weight retention following pregnancy, the postpartum period has been identified in the literature as an “especially critical” period for changing behaviours to promote more healthful weight management in women (Kummel, 2007: 37). Despite the lack of evidence, the postpartum is increasingly positioned in the literature as representing a “teachable moment” (McBride et al., 2003: 156) and unique opportunity to “alter embedded attitudes and habits and adopt new activities and, therefore, to address obesity” (Furness et al., 2011: 2). Stapleton and Keenan (2009) in a qualitative study which looked at food and consumption practices among pregnant women in the UK, likewise suggest that “early family formation may be seen as opportunities for women, family and friendship networks to examine and revise habitual behaviors, attitudes and expectations, including those relating to food and other consumption practices” (2009: 119). Other studies too have positioned postpartum as a time when many women are concerned about and want to lose weight (Heslehurst et al., 2015; Smith and Lavender, 2011; Wilkinson and Tolcher, 2010). Some studies have suggested that the weight lost naturally after birth may act as a motivator and

positive reinforcement for continued weight loss (Østbye et al., 2008). According to Peterson et al. (2002) the postpartum period provides a 'window of opportunity' for behaviour modification, although the authors argue that effectiveness of interventions are dependent upon how well social contexts and other barriers and constraints are addressed within the intervention. However these are social and contextual factors which we currently have a very limited understanding of.

A number of other studies have also pointed to the perceived lack of support available to obese women in postpartum (with regard to weight management) as an impediment to successful weight management during this period. Heslehurst et al. (2015) in a UK based study evaluating the implementation of existing maternal obesity care pathways from the perspectives of obese pregnant women and health care professionals, reported that although women described being motivated to engage in weight management in postpartum, most indicated that weight-related support was "inadequate" (2015: 11). Ferrari et al. (2010) in a US based study, assessed clinician advice on postpartum weight loss and physical activity in 688 women at three months postpartum. Results showed that the majority of women reported receiving no weight loss or physical activity advice during the postpartum period (see also Ohlendorf et al., 2012).

In addition, Van der Pligt et al. (2013) suggest that because face-to-face contact between health professionals and women is less frequent during the postpartum period in comparison to pregnancy, there is less opportunity for health professionals to adequately address weight management. In light of the absence of adequate support in postpartum, it has been argued that for many women it might be better

conceived of as a ‘missed opportunity’ for clinically directed weight management (Miller et al., 2014).

## **2.7 Predictive factors influencing weight retention in postpartum**

Much of the discussion in the literature pertaining to postpartum has focused on identifying individual, biomedical risk factors or ‘predictive factors’ for postpartum weight retention. Predictive factors for postpartum weight retention, although fraught with contradiction and incongruity, most frequently highlighted in the biomedical literature include, but are not limited to: excessive gestational weight gain (Olson et al., 2003; Vernon et al., 2010); high pre-pregnancy BMI (Davis et al., 2009; Gunderson et al., 2001); parity versus nulliparity (Davis et al., 2009); low socioeconomic status (Walker et al., 2006); poor diet (Nuss et al., 2006); low levels of physical activity (Wilkinson et al., 2004); limited duration and/or failure to breastfeed (Baker et al., 2008; Gore et al., 2003); and, depression (Herring et al., 2008).

However, beyond the more obvious recognition of predictive factors and biomedical risk factors for postpartum weight retention, a comprehensive understanding of specific behavioural factors framed and influenced by social norms and circumstances are not well understood (Ball and Crawford, 2006). As discussed earlier, aside from economic and material wealth influencing obesity, social norms regarding body weight, physical activity and eating, levels of social support for obesity-protective behaviours, social capital, social and cultural customs, values or expectations for what is important in relation to the role of food, or for example, the

acceptability of physical activity/exercise (Ball and Crawford, 2006), also play a role and interact in complex ways.

While it has been well established that there is a direct, inverse relationship between obesity rates and income levels, particularly amongst women (Scottish Health Survey, 2014), there are also a number of knock-on effects arising from socioeconomic health-related disparities. For example, research has suggested that breastfeeding confers certain benefits to the mother and is purported to act as an accelerant and mechanism for facilitating weight loss in the postpartum period (Baker et al., 2008; Kramer and Kakuma, 2002). However, research has also indicated that high pre-pregnancy BMI has a negative association with breastfeeding, so women who are potentially at greatest risk for postpartum weight retention (those from low-income backgrounds), are the least likely to breastfeed and, when they do, they are likely to do so for a shorter duration. (Donath and Amir 2008; Liu et al., 2010). No doubt, there are also extensive cultural, social and workplace maternity arrangements that make generalising fraught with difficulties, and this, too, is indicative of the need for further investigations looking at contextual factors and processes that may have a significant impact on postpartum weight management amongst women.

## **2.8 Understanding health-related behaviours in postpartum**

Despite the fervor with which the postpartum period is presented as a ‘window of opportunity’, to date there has been little exploration into the reality of postpartum life. In particular, there is a dearth of qualitative studies focusing on the experiences of obese women during this period. Few qualitative studies have attempted to explore

the real and perceived obstacles, enablers and their respective associations with the successful return to pre-pregnancy weight in the postpartum period, and those that have, have done so tangentially at best. Core assumptions pertaining to the postpartum period have primarily been derived from women considered to be of 'normal' weight and, more often than not, women from middle-class backgrounds (Walker et al., 2004b). Indeed the lack of research (and the lack of clarity in the existing research) has been identified as a major stumbling block to the development of effective lifestyle interventions for obese women in postpartum (Downs et al., 2014; see also Maturi et al., 2011; Wiltheiss et al., 2013). Moreover, although guidelines do exist for weight management in postpartum for obese women (NICE, 2010), these guidelines are general at best. It is also noteworthy that none of the existing studies have examined the strategies and approaches (if any) that obese women use to manage their own weight in postpartum.

Moreover, to-date research focusing on postpartum has largely ignored the temporal dimensions of this period and has tended to focus attentions on a single 'snapshot' in time or appears to have chosen rather arbitrary points at which to collect data. There are for example no qualitative studies, of which I am aware, that have attempted to look at obese women's experiences of weight management at multiple time points over postpartum. One of the few studies to address the notion of an 'optimal' time for women to begin to address any postpartum weight gain, did so by using a survey to explore the differences in women's 'readiness' to adopt health behaviours across time points (post-birth, four weeks and eight weeks postpartum) (Ohlendorf, 2012). These researchers found that, during the post-birth hospitalization in a US setting, most women in the sample were contemplating making health behaviour change and,

accordingly, these women were considered to be “perfect candidates” for intervention during this “teachable moment” (2012: 66). Although the results should be interpreted thoughtfully, as a considerable number of women were not available for follow-up and results were limited by “accuracy of self-report” (Ohlendorf, 2012: 66), nevertheless, employing longitudinal, repeat phases of data collection at different time points, has the potential to offer valuable insights into this period.

In the following section, I attempt to look more specifically at some of the research which has attempted to explore the barriers and facilitators to weight management which women<sup>10</sup> encounter in postpartum. I pay particular to the research looking at physical activity and eating as these are factors which are highly salient to this study. Finally, I briefly draw attention to some considerations unique to the mother role which appear to further problematise engagements with health-related behaviours in postpartum.

### **2.8.1 Barriers and facilitators to health-related behaviours in postpartum**

Existing research has attempted to identify some of the barriers and facilitators to the adoption of healthy behaviours during postpartum. It has argued that weight management in postpartum is in large part determined by a woman’s historical approach to weight management - that is a woman’s pre-pregnancy weight status, eating behaviours and physical activity habits. Devine et al. (2000) conducted

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<sup>10</sup> Given the dearth of research looking at the experiences of large women in postpartum, much of the research presented here concerns women considered to be of ‘normal’ weight. However, when referring studies which have focused on obese/large women I note that in the text.

multiple, in-depth interviews with 36 women (mostly White, well educated and living in the US) from pregnancy through to one year postpartum, enquiring about weight orientations and lifestyle practices. These researchers reported that pre-pregnancy orientations towards body weight proved to be the dominant influence on women's attitudes to their body weight postpartum, with very few women diverging from those trajectories. Arguably, these conclusions could have significant implications for postpartum health behaviour interventions, and bring into question the notion, prescribed by many, that postpartum is an 'ideal' time for health behaviour change.

In another US based study using group and individual interviews in pregnancy and postpartum among low-income women, Graham et al. (2014) report that many challenges detracted from their participant's capacity to successfully manage their weight in postpartum, including "personal health conditions as well as children's health problems and environmental constraints" (2014: 9). Based on these findings the authors suggest that given the complexities of women's lives and the imbricated nature of various individual and structural barriers, that their research "raises concerns about the efficacy of behaviour change theories" (2014: 9).

### 2.8.1.1 Physical activity<sup>11</sup> in postpartum

A number of studies have also highlighted declines in, and low levels of, physical activity and increases in sedentary behaviours across the transition to postpartum and motherhood (Albright et al., 2006; Evenson et al., 2013; Hull et al., 2010; McIntyre and Rhodes, 2009; Ohlin and Rossner, 1994; Oken et al., 2007; Olson et al., 2003; Rhodes et al., 2013). A limited number of studies have suggested that this is especially true for obese women (Durham et al., 2011; Evenson et al., 2013).

Furthermore, research exploring the factors which influence physical activity in postpartum are limited. Existing research among women considered to be of 'normal' weight, suggests that women who are active prior to conception and women from families with higher incomes, are likely to be more active during postpartum (Grace et al., 2006). Other studies have reported a number of barriers to physical activity during postpartum including but not limited to: lack of time, energy, child care issues (Albright et al., 2015; Hamilton and White, 2010; Bellows-Riecken and Rhodes, 2008); guilt, lack of support, scheduling constraints, work (Mailey et al., 2014); other children in the household (Pereira et al., 2007); and,

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<sup>11</sup> A note on terminology: physical activity is defined as "any bodily movement produced by skeletal muscles that results in energy expenditure...(and) can be categorized into occupational, sports, conditioning, household, or other activities" (Caspersen et al., 1985: 126). Physical activity should not be confused with exercise which is considered "a subset of physical activity that is planned, structured, and repetitive and has as a final or an intermediate objective the improvement or maintenance of physical fitness" (Caspersen et al., 1985: 126). Sedentary behaviours are considered a distinct class of behaviours set apart from physical activity, typically characterised by sitting and most commonly include; watching television or sitting at a computer and are associated with very low levels of energy expenditure (Ainsworth et al., 2011). Sedentary behaviours are also thought to have significant implications for health (Katzmarzyk, 2010). Owen et al. (2010) suggests that there is a crucial distinction between "too much sitting" and "too little exercise", pointing out that adults can satisfy "public health guidelines on physical activity, but if they sit for prolonged periods, their metabolic health is compromised" (Owen et al., 2010: 105).



physical discomfort, financial constraints, neighborhood safety and weather (Chang et al., 2008; Evenson et al., 2009; Groth et al., 2008). In one small scale, US based interview study, which recruited women who had participated in a randomized controlled behavioral intervention trial to promote postpartum weight loss through diet and increased physical activity, Carter-Edwards et al. (2009) reported that, despite a desire to engage in healthier behaviours, the women in their study often found it too difficult to adhere and commit to making lifestyle change during postpartum. Women in this study reported a number of barriers to adopting a healthier lifestyle in the postpartum period, including: 1) time availability; 2) prioritising other competing life responsibilities above their own health; 3) support from family members, friends, and/or co-workers; and, 4) lack of flexibility in the intervention structure.

In one of a limited number of studies which has attempted to explore the beliefs of women in the postpartum period, Evenson et al. (2009) looked at the physical activity beliefs, barriers and enablers among postpartum women, employing a mixed methodology. This study comprised both structured and open-ended questions which were delivered to a cohort of 667 women who had given birth at University of North Carolina Hospital. Telephone interviews were conducted with participants at three months and 12 months postpartum. Results of the study indicated that more than 87% of women considered “exercise and physical activity were appropriate at three months postpartum, even if they continued to breastfeed” (2009: 1925).

Furthermore, the most common barrier to physical activity reported was insufficient time and childcare issues. Researchers reported no noticeable differences between data collected at three and 12 months postpartum. Most commonly reported enablers

were ‘partner support’ and a ‘desire to feel better’. Other interesting themes emerged, for example, participants who received guidance from a health professional regarding physical activity in the postpartum period were “much more likely to agree that it was acceptable to increase physical activity or exercise compared to those who had not received advice” (2009: 1932). Whether these women were then more likely to undertake physical activity was not explored. The authors also report that, although some barriers reported were congruent with previous studies on women, “others were unique to women in the postpartum period” (2009: 1932). The findings, particularly those identified as being ‘unique’ to postpartum where not clearly elucidated and underscore the need to explore and investigate this period in a more in-depth manner. Reflecting the general tenor of the existing research, women recruited into Evenson et al.’s (2009) study were more likely to be White, married, college educated and reporting excellent general health, a demographic that is certainly not representative of the entire population. Moreover, this study was conducted in the US and I would argue that the UK context is likely to be quite different.

While obese women may experience many of these same ‘beliefs’ and barriers to those of the women in the studies above, there is nonetheless limited understanding of the “unique challenges” these women may also experience around physical activity (Downs et al., 2014: 194). Indeed Wathne (2011) in an article based on a case study of a Norwegian paediatric obesity patient, has argued that obese individuals may have very different “corporeal experiences” than people of other weight categories (2011: 415). In one US based qualitative study, Chang et al. (2008) found that obese postpartum mothers’ “personal experiences of physical discomfort”

(for example knee and back pain) and their “body size” made physical activity difficult (2008: 1025). However, as women were recruited from three months and ranged in age from 18 to 35 years of age, the proximity to giving birth and/or the age of the participant may have significantly impacted on these findings. Further qualitative research investigating barriers, contextual factors and their impact on weight retention in the postpartum period is certainly warranted, particularly with a UK focus, as this has largely been neglected to date. Moreover, none of these studies have explored how large women conceptualise physical activity in postpartum and, most notably, notions of embodiment have largely remained invisible and absent.

#### **2.8.1.2 Food and eating practices in postpartum**

Only a few studies have specifically explored changes in food and eating practices during early postpartum and no studies that I am aware of which have explored how obese women engage with these behaviours overtime. Furthermore, most of the existing studies looking at changes in food and eating practices during the period have tended to look at the impact of the transition on first-time mothers and parents (see Aschemann-Witzel, 2013; Bassett-Gunter, 2013; Devine et al., 2000). Moreover, existing studies have reported contradictory findings.

In a US based prospective cohort study which followed women from mid pregnancy until two years postpartum and explored food choices via mailed questionnaires prior to pregnancy, during pregnancy and again at six months, one and two years postpartum, Olson (2005) showed that certain eating choices such as eating breakfast and eating more fruits and vegetables improved during pregnancy and were maintained for up to two years postpartum. This was particularly notable tend among

first-time mothers. However, other studies have suggested that whilst women may eat healthier foods during pregnancy, they may discontinue these healthy eating habits after giving birth (George et al., 2005). More recent studies have suggested that the quality of women's diet is 'sub-optimal' during the postpartum period (Fowles and Walker, 2006), particularly among overweight and obese women (Durham et al., 2011; Wiltheiss et al., 2013).

### **2.8.1.3 Mothering**

Other research hints at further complexities regarding the barriers and facilitators to weight management in postpartum. A University of York and NICE (2007) review of postpartum reported that the challenges that women encounter during the postpartum period may vary according to a host of factors. The review goes on to suggest that whatever women's individual circumstances "all women have to deal with the day to day demands of the care of a new baby, while also meeting their own physical and emotional needs" (2007: 11) and, arguably, in many cases, the needs of other family members as well. It has also been acknowledged that motherhood is imbued with heavy responsibilities and the overarching imperative to make self-sacrifice and this may have a significant impact on postpartum behaviours.

Lupton (2011) reporting on the findings from an Australian study involving interviews with 60 mothers, posits that the ideal of a good and responsible mother is a mother who puts the needs of the infant before her own. This observation is echoed in a US based qualitative study by Chang et al. (2008) which looked at motivators and barriers to healthful eating and physical activity among low-income overweight and obese women in postpartum. Chang et al. found that although

women were aware of the “importance” of engaging in healthy behaviours for weight management, they tended to focus on their children’s needs first, “often to the point of neglecting their own personal needs” (2008: 1026). This contention could certainly be seen to challenge the notion that postpartum is a ‘window of opportunity’ for effective health promotion among mothers. Indeed, in a study involving interviews with 30 Australian mothers from different socio-economic backgrounds, all of who had a BMI > 30 kg/m<sup>2</sup>, Warin et al. (2008) reported that “participants found it difficult to act on health promotion initiatives as their relational identity put individual needs as a low priority” (2008: 107). Study participants reported that finding time to engage in physical activity and exercise was “difficult in a family context where young children and/or work took priority (Warin et al., 2008: 107). Moreover, for many women, ‘being chubby and cuddly’ was seen as “inseparable from some very positive aspects of what it was to be a mother” (Warin et al., 2008: 107). Research has also shown that, for postpartum women, ignoring weight management during the early postpartum period may be common when faced with the daunting task of caring for a new born. For example, some obese women may have “attempted weight loss previously, or retained weight after an earlier pregnancy, and feel conflicted or powerless to attempt this change at the present time” (Walker et al., 2004a: 424).

Other studies have reported that the postpartum period and the transition to mothering as a time when women feel an “altered perceived personal control”, the idea that “life, decisions, and personal environment were being controlled by someone or something else” (Sterling et al., 2009). One can surmise that lack of

perceived control could have a significant impact on one's ability, or apparent ability, to adopt a healthy lifestyle, again prompting a need for further investigation.

An interesting juxtaposition highlighted in the above studies is the idea that postpartum represents both a period of major life transition where women's attention to their health is often superseded by the needs of her child and conversely, the suggestion that postpartum can be viewed as an opportunity to address weight issues and encourage women to make lifestyle changes. It would seem these assertions are in direct conflict. This in particular points to the need to conduct research which allows an in-depth view into the lives of women in postpartum, so as to elucidate the potential tensions between these assertions and how they are experienced by women.

Up to this point, this literature review has focused primarily on the biomedical aspects of maternal obesity. In particular, I have highlighted the role of postpartum weight retention in the development of obesity and dearth of research looking at obese women's experiences of weight management in postpartum. The remainder of this review will introduce some key concepts related to the body, which were influential and informative in my research design. As indicated at the start of this chapter, the literature discussed here largely reflects my reading in the earlier stages of my PhD process and is, thus, built upon and added to in later chapters.

## **2.9 The body, identity and feminine ideals**

### **2.9.1 Introduction**

As highlighted in the introduction to the chapter, my first intention with this study was to address certain gaps in the existing biomedical scholarship and the dearth of

research looking at how large women experience and engage with their health and weight management following childbirth. In addition, I also sought to elucidate these experiences and engagements from an embodied perspective: I wanted to try to understand some of the more “practical aspects of experience” (Watson, 2000: 5) and to explore how my participants felt about and experienced their bodies on a day-to-day basis. For example, among other things I was interested in exploring what it felt like to have and be a large body and the implications, if any, for weight management during the postpartum period. Although I will return to and explore the notion of embodiment in further detail in Chapter 3, in the following section I begin to explore a number of key sociological constructs of the body and the feminine ideal within the modern Western context. I argue that such an overview is useful to understanding some of the ways in which the postpartum body is constructed, interpreted and positioned in the existing literature.

### **2.9.2 What is the body?**

In Western sociological tradition and its antecedent, Western philosophy, ‘the body’ has and continues to present something of a conundrum. A difficult conceptual problem, the complexity of which is rather naively obscured in the simplicity of the question: What is the body? An Achilles heel of sorts for sociological tradition, ‘the body’ symbolises, among other things, an uneasy marriage in the attempts to explain both the blatant materiality and the social constructedness of the body; that is, the ways in which society and discourse play out and are in essence mapped out and reproduced on the body. The body in the sociological tradition is at once natural and

constructed, biological and social, discursive and lived in the reality of our daily lives:

The body social is many things: the prime symbol of the self, but also of the society; it is something we have, yet also what we are; it is both subject and object at the same time; it is individual and personal, as unique as a fingerprint or an odour plume, yet is also common to all humanity...The body is both an individual creation, physically and phenomenologically, and a cultural product (Synnott, 1992: 26).

In rather more simplistic terms, Longhurst (2001) defines the body as 'real' (having a weighty materiality) while at the same time being socially, culturally and historically constructed. Yet, such complex views on the body mark a notable departure in the history of philosophy where the body has long been conceptualised primarily in biological terms, as a separate and inferior entity to the mind, in what has been coined as a 'Cartesian dualism' or more colloquially, as the 'mind-body divide'. Elias (1991) describes the notion of Cartesian dualism as a philosophy which fostered the idea that as humans we are akin to 'thinking statues' (1991: 113). Essentially the idea posited by Cartesian dualism is that the mind is encased within an untrustworthy body and that we should "somehow seek to live life apart from our bodies" (however unrealistic) (Shilling, 2012: x). Despite the criticisms leveled at Cartesian dualism, it has formed the epistemological underpinnings through which we understand sociology, medicine, law, politics and constructs such as gender, to mention but a few (Grosz, 1994).



### 2.9.3 The legacy of dualism<sup>12</sup>

Although Cartesian conceptualisations of the body have since fallen from academic favour, the effects of such a reductionist philosophy have remained tacitly and steadfastly entrenched culturally, academically and socially. Moreover, it has been argued that Cartesian dualism (and the maligning of the body) has been used to stigmatise and control certain individuals and groups who have been portrayed as being *more corporeal* than others. These include but are not limited to; colonised populations, those in the lower classes, ‘fat’ individuals and women (see Alcoff, 2005; Bordo, 2003). Williams and Bendelow (1998) argue that these dualisms in particular have been “mapped onto the gendered division of labour in which men, historically, have been allied with the mind, culture and the public realm of production, whilst women have been tied to their bodies, nature and the private sphere of domestic reproduction” (1998: 1). Grosz (1994) adds that the assumption that “women are somehow *more* biological, *more* corporeal, and *more* natural than men” has given way to certain ideologies and normalising discourses about women and their bodies (1994: 14). For example, Bordo (1993) argues that not only have women been ‘tied’ to their bodies but ‘limited’ by historical ideologies which positioned women’s reproductive organs as ‘unruly’ and capable of exerting an irrational power over them (see also Kukla, 2005). These discourses, in turn, have been used (among other things) to construct women’s bodies as posing a threat to the foetus (Rothman, 2000), have encouraged intense medical intervention during

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<sup>12</sup> A note on terminology: I use both the term ‘Cartesian dualism’ and ‘dualism’ interchangeably throughout this thesis. However, I do acknowledge that the term ‘dualism’ can also be used to refer to binary opposites, in the general sense.

pregnancy (Martin, 2001), and have underscored conventional gender roles and continues to foster the idea that women (as opposed to men) are ‘naturally’ better caretakers of children (Fox, 2009). As I will show in later chapters, these discourses often permeate women’s own ideas about ‘good’ mothering, which have some notable implications for how women approach their health and engage with health related behaviours<sup>13</sup> in postpartum.

In the academic sense, the body in the sociological tradition has also been affected by the legacy of dualism, and up until the early 1990s has maintained a kind of ‘absent presence’ in the discipline (Shilling, 2012). Indeed, Shilling argues that sociology has displayed a rather “schizophrenic attitude” towards the body, while on the one hand “failing to provide explicit theories on which a sociology of the body could be built, yet having much to say about the embodiment of social existence” (Shilling, 2012: 25). It has been argued that the treatment of the body in sociology lies in part with sociology’s eagerness to maintain itself as a separate discipline. In an effort to do so, sociology has historically tended to ignore the body, as it pushed back against any “variants of biological reductionism that accounted for human behaviour, institutions, inequalities with reference to their natural ‘biological’ basis” (Shilling, 2012: 30). Indeed a similar reticence has been experienced in feminist scholarship, grounded in a desire to avoid further ‘biologising’ of women’s bodies and with particular pertinence to this study, has resulted in certain embodied aspects of mothering in everyday life remaining largely absent from existing scholarship (Doucet, 2013). It is not my intention to argue that no work has focused on

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<sup>13</sup> Within the context of this study ‘health-related behaviour’ specifically refers to eating a healthy diet and engaging in physical activity.

embodiment and mothering. However, rather ironically when the body has received attention in the existing scholarship, the focus has been on key ‘biological events’ relating to “infertility, pregnancy and breastfeeding” and have failed in large part to address embodiment in day-to-day existence (Doucet, 2013: 287). Frost (2011) also draws attention to this irony and posits that feminists are likely to be “suspicious of any ‘biologizing’ move that might, advertently or inadvertently, dress up power relations and disciplining norms as a force of nature or biological imperative” (2011: 74).

#### **2.9.4 The body and identity**

Although historically absent from sociology, the past two decades have seen an exponential rise in academic interest in the body. The growth of interest in the body is in large part reflective of a broader social and cultural focus on the body. The increased significance of the body in modern Western culture has been attributed, in part, to the gradual ‘desacralisation’ of social life, the rescission of grand political narratives, and the rise of both individualism and consumerism (Crawford, 2006; Shilling, 2003). Giddens (1991) argues that with the dissolution of cultural and religious tradition, we find ‘ontological insecurity’ and a reflexive focus on the body, as a means of grounding individual identity. Understood in this way, the body in Western culture, its shape and its appearance, take on added significance. As such, bodies are increasingly seen as the central means by which we express our sense of individual identity - a ‘project’ to be worked at, shaped and improved (Crozier, 2010; Longhurst, 2001; Mellor and Shilling, 1997; Rudofsky, 1986; Shilling, 2003; Turner, 1991).

Concomitantly, the preoccupation with and pursuit of health in Western societies is also constructed in a similar manner; chiefly, through the corporeal self and the ‘appearance’ of health, manifested in a thin and toned body (Lupton, 1996). It has been argued that the pursuit of health through “work on the body” has become a central means by “which the individual can express publically such virtues as self-control, self-discipline, self-denial and will power – in short, those qualifications considered important to being a ‘normal’, ‘healthy’ human being” (Peterson and Lupton, 1996: 25). Engagements in these corporeal projects are predicated on what Williams (1998a) suggests is a ‘mind over matter’ ideology and the belief that the body is something that needs to be controlled and can be controlled. The conviction that the body is by nature inherently weak and in need of discipline can also be traced back to dualist traditions. Enmeshed in the supposition that the body inherently lacks control (but can be controlled), is the notion that it is analogous to a machine. This sort of relationship with the body is reflective of the “disciplined body” described by Frank (1991). It is a view which suggests that by focusing on “regimentation” (for example, healthy eating and purposeful physical activity) the body becomes “predictable” and thereby controllable (1991: 55). Frank contends that when the body is viewed in this way it is always “lacking” and that regimentation does not “remedy this lack, but it can forestall total disintegration” (1991: 55). Turner (1992) argues that there is also strong historical links between ‘religious asceticism’ and the approach to health (physical activity, diet and sexual desires) which have served to promote vigorous self-regulation as a morally virtuous behaviour; “the growth of theories...appears to be closely connected with the development of the idea that the body is a machine, the input and output

requirements of which can be precisely quantified mathematically” (1992: 182). The aforementioned ideological perspectives play a significant role in dominant obesity discourse, where ‘fatness’ is typically positioned as representing a failure, lack of control and as a simple equation of input versus output and therefore controllable, if one is simply ‘disciplined’ enough.

### **2.9.5 ‘The feminine ideal’ and the overweight body**

It is from the roots of dualism and the epistemological alignment of women with the corporeal and the biological, that I take the leap to the notion of a body-centric, feminine ideal. I have argued thus far that moral judgments about the self (and others) are increasingly based on the appearance and size and shape of the body. This is particularly true for women, as they enact discipline and self-control in their attempts to manage their appearance and bring their bodies in line with cultural ideals about beauty through weight management and other aesthetic pursuits (Bordo, 1993; Wolf, 1991). The ever-elusive feminine body ideal that is featured in popular media is one which “promotes self-regulation through dieting, strenuous exercise, and more extreme measures (like cosmetic surgery)” (Fox and Neitherman, 2015: 672). Furthermore, it has been argued that against such a backdrop women suffer from what Rodin et al. (1994) calls “normative discontent” (1994: 267) about their bodies and even a sense of alienation from their “true self” (Bordo, 1993: 5). Others argue that the feminine ideal is better described as ‘corporeal colonialism’: the suppression and social control of women largely through their bodies (Orbach, 2011). It is oppression at its finest; labyrinthine, complex, contradictory and often

promoted and perpetuated by women themselves. Indeed Young (1990) argues that from:

the dawn of the West's distinction between reason and body, women have been identified with body and both feared and devalued as a result of that identification. But we are also desired bodies whose sexual and mothering capacities are the subject of magnificent scientific and technical manipulation. Our being is largely reduced to our bodies, the medium of male pleasure and procreation, and we find our ability to live and move freely restricted by that definition. (1990: 11)

Consider, then, that femininity is not a natural but a social construct. As a woman, the more successfully one embodies the feminine ideal, the more social currency one will yield. However, the successful manifestation of the feminine ideal is not easily won. It is a daily battle that demands that a woman "occupy" herself with a "self-image that others will find pleasing and attractive" and this, as Orbach observes, requires a tremendous deal of energy and effort to achieve (1979: 16). This struggle is painfully apparent in narratives around eating and the ubiquitous preoccupation with weight and fashion are issues now so identifiable with women's identities that they are often considered a gendered predisposition. Indeed Bordo (2004) argues that, for women, being "associated with the body and largely confined to a life centred on the body (both beautification of one's own body and the reproduction, care and maintenance of the bodies of others), culture's grip on the body is a constant, intimate fact of everyday life" (2004: 15).

It is perhaps not surprising given the earlier discussion on health that, in Western culture, the acceptable, prized and *most* attractive female form is a slender and toned body; a positive reflection of self-control (Lupton, 1994). Shilling suggests that an unparalleled significance is placed on the "youthful, trim and sensual body" (1993:

3). If we accept that assertion that the pursuit and maintenance of the body and health is instrumental in the construction of modern identity (Crawford, 2006) and that the body is the primary vehicle through which health is personified, then the 'fat' female body is accorded the most pejorative of positions. Lupton (1996) suggests that the 'fat' body is framed as gluttonous, lacking in self-discipline, hedonistic and self-indulgent, "while a slim body signifies a high level of control, an ability to transcend the desires of the flesh" (1996: 16). Brewis et al. (2011) posit that in the post-industrialised cultures of the West, where bodies are synonymous with self-identity, "slimness is associated with health, beauty, intelligence, youth, wealth, attractiveness, grace, self-discipline, and goodness" (2011: 269). Conversely, fatness and obesity are allayed with "ugliness, sexlessness, and undesirability but also with specific moral failings, such as a lack of self-control, social irresponsibility, ineptitude, and laziness" (Brewis et al., 2011: 269).

Moreover, the notion that "slenderness symbolizes self-containment, control of impulse and status for women places both a moral and emotional coding on a woman's internal state or (dis)order", is a consistent theme in feminist literature (Nash, 2005: 30). In line with these discourses, increasing attention is being paid to how women negotiate the prevailing standards of attractiveness as they manage their bodies and weight in pregnancy and in the transition to postpartum. For example, pregnancy has been positioned as a time when a woman's body can change dramatically and in ways often seen as deviating from society's thin ideals, with "residual" bodily changes continuing into the postpartum period (Clark et al., 2009: 330). Despite these bodily changes there is a general consensus in the existing literature that women tend to experience positive body attitudes in pregnancy, tied to

their mothering role (Clark et al., 2009) although this is not without complication. Nash (2012), drawing on qualitative interviews with pregnant women, their partners, and maternity industry professionals, explored pregnant embodiment against the wider sociological and feminist discourses about gender, bodies, ‘fat’, feminism, and motherhood. She draws attention to the complexities and contradictions around pregnancy and argues that, among other things, women are expected to embody both sexualised and mothering identities and to control their body size and shape “to keep the foetus healthy” while remaining slim and sexually desirable (Nash, 2012: 3). Despite the interest in bodies and notions of embodiment, how women feel about their bodies in postpartum has received less attention in the literature (Fox and Neitherman, 2015). In the following, I pay particular attention to how the postpartum body has been understood and interpreted in the existing literature.

#### **2.9.6 The postpartum body**

The existing interdisciplinary work looking at postpartum has tended to focus predominantly on how White, middle class women considered to be of ‘normal’ weight, experience bodily changes associated with pregnancy, more often focusing on their experiences of ‘fatness’ and their apparent preoccupation with the desire to ‘return’ the body back to its pre-pregnancy shape in postpartum. Rather problematically, this scholarship has tended to presume these as universal experiences among all women.

Indeed much of the existing scholarship has tended to employ quantitative methodology and, using various measures designed to assess body attitude, have focused on exploring levels of body satisfaction/dissatisfaction in the transition from



pregnancy to postpartum. Although there is some conflicting evidence (see Strang and Sullivan, 1985; Suttie, 1998), in general these studies have reported that the postpartum period is a time when women experience increased body dissatisfaction (Clark et al., 2009; Gjerdingen et al., 2009; Rallis et al., 2007). There is also a general consensus among these studies that women's dissatisfaction with their bodies is largely attributed to increases in body weight and size. In line with the dictates of normative femininity, a number of these studies have conjectured that bodily dissatisfaction may arise from the fact that women feel like they no longer have an 'excuse' to be 'fat' as they transition from pregnancy to postpartum (see Pauls et al., 2008; Rallis et al., 2007).

Some studies employing qualitative methods have also attempted to explore women's experiences of their bodies in postpartum, but to-date there are no studies of which I am aware that have looked at how large women experience their bodies during this period. A key theme which has emerged from the existing research centres around the idea that discourses of femininity are increasingly emphasising the control of the body in the postpartum period and that a primary concern for women revolves around "whether they will 'bounce back' to their pre-pregnancy weight and body shape" (Nash, 2015: 18). For example, in a qualitative study of 14, mostly white, educated, married couples who were expecting their first child, Ogle et al. (2011) argued that a central and profound concern for many of the women in their study revolved around whether, after the pregnancy, their bodies would return to 'normal'. The authors also conjectured that the body may in fact "become the site of a struggle to redefine and refigure (the self) after childbirth" (Ogle et al. 2011: 29; see also Bailey, 2001; Clark et al., 2009; Upton and Han, 2003). Similarly, in a

longitudinal study of pregnancy and the transition to motherhood among US women, Oakley (1980) argued that women in her study felt “primarily and essentially a loss of identity” in the postpartum period, a part of which was a sense of grief resulting from the ‘loss’ of their former bodies (1980: 244). In another study, Lucy Bailey (2001) offered an empirical and theoretical account of gendered embodiment amongst British middle class pregnant and postpartum women. She argued that how her participants felt about motherhood seemed to be in large part predicated on the corporeal changes they experienced in pregnancy and postpartum. Similar to some of the other studies described above, she also argued that feelings about ‘fatness’ were a significant concern for many of the women. Some of Bailey’s participants, for example, described feeling “invisible” (in the public sense) in postpartum – an invisibility which seems to have been predicated on the notion that their (‘fat’) postpartum bodies were no longer as attractive (2001: 124). Given my earlier assertion regarding the notable absence of research looking at how large women experience their bodies in postpartum, it would seem that this sense of ‘invisibility’ is endemic in the academic sense too.

Other qualitative studies have suggested that postpartum women experience their bodies as being ‘out of control’. For example, in a qualitative study of 60 middle class, American women transitioning back into the paid workforce, Upton and Han (2003) show how their participants typically characterised their bodies as being ‘out of control’ in pregnancy and that postpartum period was marked by attempts to “regain a lost body, or a particular kind of identity through the body” (2003: 686). To this end, Cunningham (2002) argues that women who retain control of their bodies

and “retain sexiness in the midst and aftermath of biological reproduction can appear particularly valorous” (2002: 443).

Other studies have highlighted the importance of women’s roles in the transition to postpartum albeit with contradictory findings. Clark et al. (2009) conducted a qualitative study exploring Australian women’s experiences of their body and mood during pregnancy and the postpartum. The authors reported that while most of the sample reported adapting positively to body changes experienced during pregnancy, the postpartum period was typically associated with body dissatisfaction. The authors suggested that women seemed to cope positively with bodily changes (for example gaining weight and having larger breasts) in pregnancy because they identified those changes as playing an important functional role. However, in the absence of those explanations from which to draw on in postpartum, women expressed dissatisfaction with their bodies.

Other qualitative studies, however, have noted that women’s new roles in the postpartum involve a shift away from more aesthetic concerns about the body. Using qualitative methodology, Fox and Neitherman (2015) explored 48 Canadian women’s experiences of their postpartum bodies and their sense of self. The authors suggested that, for many women, motherhood afforded them an appreciation and a “positive embodied sense of themselves” but only if they perceived their bodies as performing maternal functions well (i.e. breastfeeding) (Fox and Neitherman, 2015: 670). In addition the authors reported that many of the women they interviewed suggested that the “demands of childcare – shaped substantially by the ideologies of ‘good’ mothering – largely overrode worries about appearance” (2015: 689). Finally,

the authors cautioned that as interviews were conducted with women at a single time point in postpartum, how women negotiated the “disjuncture” between normative “body ideals” and the corporeal reality of their bodies may have changed over time. Accordingly, they go on to suggest that future studies employing several interviews with the same person over time could proffer useful insights.

## **2.10 Summary**

I began this chapter by discussing maternal obesity and the heightened concern regarding weight retention in postpartum, particularly for women who are already considered obese. As discussed previously, postpartum weight retention has been recognised as an important precursor to long-term weight gain and significant future health problems for the mother and subsequent generations. Indeed, for many women, the postpartum period is also the preconception period for their next pregnancy and as such, the failure to lose weight between pregnancies heightens risk for all future pregnancies. Consequently, postpartum has been identified as a critical period to promote successful weight management in women. Indeed, a salient feature of much of the existing research and clinical guidance (albeit limited) around weight management following childbirth, is the underlying assumption that postpartum is an important ‘window of opportunity’ and a time when women are highly motivated to engage in health behaviour change. Yet, despite such assertions there is in fact little, if any evidence to confirm if this is indeed the case.

In particular, this review has drawn attention to the dearth of qualitative research looking at women’s experiences of their bodies and perceptions of weight in postpartum, together with their willingness and perceived ability to diet and be

physically active to lose weight during this period of their lives. Furthermore, there are few, if any studies, which have explored how mothers, and in particular large mothers, perceive their health, experience health and engage with health-related behaviours at this particular point in the life course. Indeed little, if anything, is known about whether weight management is in fact a salient concern for large women during this time. Moreover, there is very little understanding of the lived, embodied, social and contextual factors which might influence weight management for large women in postpartum. Crucially, existing research has done little to enhance our understandings of the lived, embodied and practical realities of caring for an infant and how this impacts health and engagements with health related behaviours. For example, few qualitative studies have attempted to explore the real and perceived obstacles, enablers and their respective impact on the successful return to pre-pregnancy weight, with core assumptions typically derived from women considered to be of 'normal' weight. Moreover, we know little if anything about the strategies, if any, which large women employ to self-manage their weight in postpartum. Previous, albeit limited research has suggested that weight management following childbirth, is significantly influenced by what woman has done previously, with few women diverging from those trajectories. However, this is an assertion which brings into question the notion of postpartum as a 'window of opportunity' and, is one which necessitates further enquiry. Overall the lack of research and clarity has been identified as a significant impediment to the development of effective lifestyle interventions.

Furthermore, to-date research focusing on postpartum has largely ignored the temporal dimensions of the period and has failed to consider how understandings of

health and engagements with health-related behaviours might conceivably evolve and change over postpartum. Indeed, one of the few studies (Ohlendorf, 2012) which explored women's receptiveness to engage in health behaviour change at three different time points in the first eight weeks following childbirth, reported a 'readiness' amongst women to engage in health behaviour change. However, these researchers did not explore whether such intentions resulted in actual health behaviour change. Therefore a qualitative study, employing longitudinal methodology, such as the one described in this thesis, has the potential to offer meaningful insights into how health behaviour change plays out in reality and over time.

Finally, this review has drawn attention to a small but growing body of literature which has paid attention to the body and notions of embodiment in postpartum, however, as discussed much of the existing research has been quantitative in nature. As previously described the limited qualitative research in this area has tended to focus predominantly on women considered to be of 'normal' weight. Moreover, this research has almost exclusively focused on how women negotiate the apparent disjuncture between idealised feminine body ideals and the corporeal ('fat') realities of their postpartum bodies. This is also a corpus of work which has ignored how large women might experience and navigate those changes (if any) in postpartum.

I conclude by arguing that understanding attitudes towards the body, weight and health-related behaviours and how, and why, these attitudes may change and adapt over the postpartum period, and the impact and role of a host of contextual factors, is pivotal if we can begin to tailor and target suitable and successful health initiatives.

## **2.11 Research aims**

- 1) To explore the experiences, attitudes and health-related behaviours among women with a BMI  $\geq 40$  kg/m<sup>2</sup>, following childbirth; and to identify the factors and considerations which shape and influence their experience, perceptions and attitudes, and how these may change over time.
- 2) To gain an understanding of the meaning and constructions of health, attitudes towards the body and weight, and engagements with health-related behaviours in the lives of women with a BMI  $\geq 40$  kg/m<sup>2</sup> and how, and why, these meanings, constructions and attitudes may change over the postpartum period.
- 3) To determine if women with a BMI  $\geq 40$  kg/m<sup>2</sup> are receptive to advice and able to implement weight management and other lifestyle changes during the postpartum period.
- 4) To explore at what points in the postpartum period women are most likely to be amenable to advice/intervention; and, how could weight management and lifestyle advice be best tailored to suit their personal circumstances and needs?

### **2.11.1 Research questions**

- What are the lived experiences, perceptions and expectations among women with a BMI  $\geq 40$  kg/m<sup>2</sup> over the postpartum period; and how, and why, do these change? What contextual factors shape and influence these expectations and experiences?

- What are women's ( $\text{BMI} \geq 40 \text{ kg/m}^2$ ) perceptions and attitudes towards their body, current and past weight, weight management (diet and physical activity) and lifestyle change in the postpartum period. How and why do these perceptions and attitudes change or stay the same over the postpartum period?
- Do women want to do something to manage their weight in the present? What are their historical experiences of weight management/attempting to lose weight? Have these experiences shaped and influenced their present motivations in any way?
- What are women currently feeding themselves, their baby, and other family members; and, what factors and considerations influence and inform their current food and eating practices? How have eating habits changed from past practices (pre-pregnancy, pregnancy) and over the postpartum period?
- What factors influence their decision to breastfeed or not; and, influence their experience of breastfeeding and breastfeeding duration?
- How do women with a  $\text{BMI} \geq 40 \text{ kg/m}^2$  view and experience their own health and what is their attitude towards the health of the foetus/child? How is health understood and what does it mean for these women in the present? Do attitudes to health change over the postpartum period? How is health prioritised in the postpartum period? How and why do priorities shift over the



course of the postpartum period?

- What, if any, kinds of discourses (health related and/or mothering) are women drawing upon in the postpartum period? How do they engage with these discourses?
- Is there a particular point during the postpartum period when women seem most receptive to and/or are able to engage with weight management and are open to lifestyle change?

## **Chapter 3: The research journey**

### **3.1 Introduction**

In Chapter 2, I established the relevance of my research by drawing attention to, and identifying certain gaps in, the literature. In this chapter I tell the ‘story’ of my research project and, in doing so, provide a valuable ‘behind the scenes’ look at the research process. Bourdieu (1990) has argued that there is an endemic “forgetfulness” by researchers and academics of “the social conditions of scientific activity” (1990: 33) and so the following is an earnest attempt to avoid such vagueness.

I begin this chapter by offering a little background as to how I arrived at this project. Following on from there, I outline my philosophical and theoretical influences and discuss how these informed particular decisions made around the research design. I then discuss some of the ethical considerations unique to this study and in particular, I address how these considerations and concerns informed my approach to recruitment. The study sample is also briefly introduced. I then describe how the interview data were analysed and some of the problems I encountered when attempting to adhere to a prescriptive approach. Throughout this chapter, I share some of my own thoughts and reflections on the research I undertook and, in that sense, this chapter is as much a reflection on my journey through the research process, as it is a commentary on the methodology.

### **3.2 Arriving at the project**

The journey which lead me to this PhD is not necessarily straightforward nor easily articulated. While the broad thesis topic arose from a Centre for Population Health Sciences studentship which sought to explore women's experiences of weight management following childbirth using qualitative methodology, the events which drew me to apply for this studentship are the result of a number of different imbricating factors and personal experiences.

In many ways I was an unlikely candidate for this kind of postgraduate research. Prior to my arrival in Edinburgh to start my PhD I trained and subsequently worked for 10 years as an exercise physiologist in New York. Although this training was excellent in many ways, it had provided little exposure to qualitative methodologies, nor to the many schools of thought and literatures in philosophy, social science and feminist writings which have come to inform much of my thinking around this thesis. However, as an exercise physiologist, what I did have was a lot of experience working with individuals and groups who were seeking health and lifestyle change. In working with people over the years, I had become increasingly dissatisfied with individualised approaches to health behaviour change and health promotion initiatives which were predicated on conceptual frameworks which failed to account for contextual factors and the role these played in people's health behaviours and lifestyle choices. For example, I often noticed when working with people to develop strategies to improve their fitness, that even when individuals seemed well placed to make health behaviour change (by this I mean they were well informed, supported and resourced), their intentions rarely translated into practice or at least into a

sustained and consistent practice. More and more, I felt that there were complexities and nuances in people's experiences which I felt my training up until that point had left me ill-equipped to comprehend. Change came when, in 2004, I experienced events that prompted me to want to pursue further education in the field of public health and social science.

Shortly after I graduated from my master's degree in Exercise Science I was fortunate enough to be offered an opportunity to remain on and work in the health and sport science department where I had trained. One of my principle responsibilities at that time was to develop and implement a health and wellness programme for members of the local fire department. In the aftermath of the September 11<sup>th</sup> 2001 terrorist's attacks there was considerable interest and a heightened sense of concern for the health and wellbeing of firefighters in the US. Prior to taking up the position, my only real exposure to firefighters had been those portrayed in the popular media and movies: brave, valorous, healthy and fit men (mostly). Although the former characterisation of firefighters as brave and courageous certainly proved true, it quickly became apparent that the latter depiction of firefighters as healthy and fit, was for a significant number (at least in the context of this specific fire department) largely untrue. As I began to learn more about the demands of firefighting, I was surprised to learn that heart attacks were in fact the number one cause of firefighter line of duty deaths. At the time, firefighters in New York state were required to pass a stringent fitness test to get secure admission to the fire academy, however once admitted, beyond passing an annual medical, they were not required to maintain a particular level of fitness. As a result many of the firefighters that I was meeting were very overweight and obese.

As part of the project I spent a considerable amount of time in and around the districts fire stations and observed first-hand fire fighters' daily eating habits and physical activity. I worked hard to find ways to encourage and entice individuals to become involved in the project and devised countless group and individual initiatives, classes, and nutrition workshops. The initiative was funded for 12 months and whilst I encountered some resistance initially, over time the project proved highly successful – in short firefighters were eating better, exercising more, losing weight and becoming more physically fit. Although the data that I collected was exclusively quantitative in nature, I was aware at the time of the interesting qualitative questions that arose from my interactions with the firefighters, and the wealth of themes which emerged. The project left me with interesting observations regarding group dynamics, participators and non-participants, effective and less effective initiatives to health behaviour change and the role of social networks and culture in the adoption of long-term lifestyle change. These were aspects that were, at least in the sense of data collection, largely ignored.

The project came to an end some 12 months later as planned and certain contingencies were put in place which it was hoped would ensure that the initiative remained self-sustaining. For example, each of the districts' fire stations had been equipped with a gym and certain firefighters onsite had been appointed as 'stewards' of the programme. Yet, when I returned to visit a year later, I found treadmills dusty and a collective return to the 'Ready Room'<sup>14</sup> couch - emblematic it seemed of declining participation rates. I mused at the time that there were no doubt a myriad of

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<sup>14</sup> The 'Ready Room' refers to room at the main station, where firefighters wait to receive orders, eat their meal and spend their down time etc.

complex reasons as to why motivations for health behaviour change had waned. An outcome familiar to me, I recognised it related greatly to my previous observations in my earlier years as an exercise physiologist. A number of years later, while at Cornell University, I was presented with the opportunity to explore what was now a compelling, recurring theme through a series of public health and qualitative methodologies courses. Viewing these observations now, through such an academic lens, fueled my curiosity about the nuances of determinants of health. This was an interest which ultimately brought me to Edinburgh to pursue my PhD, in 2011.

As highlighted above, when I was accepted to this studentship it was under the broad remit that I would conduct a qualitative study looking at the experiences of weight management among postpartum women. While it was expected that the research would focus on the experiences and views of postpartum women, there was considerable latitude around what form and direction this research project could ultimately take. With this in mind, my supervisors encouraged me to spend a number of months reading and exploring the literature, with a view to identifying possible avenues of investigation and to refine my aims, objectives and research questions. During this time I considered a multitude of different options and, with the dearth of qualitative research in the area of health and weight management in postpartum, the gaps in the literature were relatively easy to identify. As I discussed in Chapter 2, there had been a growing emphasis in the biomedical literature around the risks of postpartum weight retention, particularly among women who were already considered obese. Moreover, as discussed, despite the explosion of interest in the topic there was in fact little qualitative research looking at the experiences of large women and their attitudes to health and weight management in postpartum and none

which I was aware of which had done so longitudinally. While I was interested in exploring the experiences of large women, I began to consider how I might go about recruiting women to participate in the study. Also, I wanted to ensure that there was some consistency around the ‘type’ of woman that I was recruiting. What I mean by this is, is that I was keen to recruit women to the study who shared a similar weight category. This seemed an important consideration, as during the first year of my PhD I had attended a number of conferences and workshops on the subject of obesity and I had been frustrated by the tendency for researchers to employ terms such obese in their work when in fact they were describing a wide range of weight categories. As such, I often found that inferences drawn were quite problematic, not least because there was some evidence to suggest that aspects of health might be experienced in different ways depending on the degree of overweight.

Initially, I considered recruiting participants through a popular community based pregnancy and parenting organisation. Whilst the organisers were receptive to the idea, they raised concerns about the numbers of suitable women I might be able to recruit through their organisation. Their concerns were two fold. Firstly, they suggested that the women who typically availed of their services wanted to give birth at home. Furthermore, women over a certain BMI are normally designated as ‘high risk’ during pregnancy and therefore are strongly discouraged from giving birth at home – a fact which they indicated might have accounted for the relatively low number of large women accessing their services. Secondly, the staff expressed concern about how women would feel about being asked to participate in study about large women and felt that it had the potential to cause offence. It was around this time that my supervisors put me in touch with Dr. Fiona Denison, one of the senior

staff at the MRC Centre for Reproductive Health at the Royal Infirmary of Edinburgh. This centre hosts a multidisciplinary specialist antenatal metabolic clinic, specifically for women with BMI  $\geq 40$  kg/m<sup>2</sup> and so it seemed an ideal location from which to recruit large women while also ensuring some kind of consistency regarding the size of the women I could potentially recruit to the study. After a number of conversations with Dr. Denison where we discussed the research proposal in more detail, she agreed in principle to support the project. However, while she was supportive of the project, because I planned to recruit women through the NHS, I would also need to be granted permission by an NHS ethical review committee before I could begin recruiting participant's onsite.

I will return to discuss the particularities of the ethics review process a little later in the chapter, but before doing so, in the following section I address some of the philosophical and theoretical influences which in turn informed many decisions around my methodological approach.

### **3.3 Philosophical and theoretical influences and considerations**

Broadly speaking, my epistemological and ontological approach is in line with interpretivism. Unlike the positivist traditions, interpretivists deny that there is a singular, knowable world, rather, perceiving that reality is multiple and relative (Lincoln and Guba, 1985). As such, this is an epistemological approach that centres on the ways in which “human beings make sense of their subjective reality and attach meaning to it” (Holloway and Wheeler, 2010: 25). Of the interpretivist traditions, in particular I have found myself drawn to phenomenology and the work of the French philosopher Merleau-Ponty (1962).



On a fundamental level, phenomenology is an approach to philosophy, although it is perhaps more commonly understood and employed as a methodology, where unfortunately confusion and neglect around its philosophical origins abound (Tufford and Newman, 2012). This is a crucial distinction because, as a methodological approach, phenomenology shares many of the central features of qualitative research that at times make it somewhat indistinguishable. For example, like many qualitative approaches to research, phenomenology concerns itself with providing a ‘thick description’ of the lived experience of individuals (Van Manen, 1990) and asks: “‘What is this experience like?’ as it attempts to unfold meanings as they are lived in everyday existence” (Lavery, 2008: 4). What makes phenomenology so unique and appealing as a philosophical approach, particularly the work of Merleau-Ponty (1962) is the notion that consciousness and perception are an embodied phenomenon. At the danger of oversimplification, Merleau-Ponty argues that all of our perceptual experiences are bodily experiences, which in turn form the basis of subjectivity. These claims mark a profound departure in the history of philosophy where, as discussed earlier in Chapter 2, “rationalism and an emphasis on a disembodied mind have been central” (Carel, 2011: 4).

I recognised from the outset that such a philosophical approach had significant implications for understanding the experiences of health and illness, which are highly pertinent to this study. Firstly, if we accept the assertion that all perceptual experiences are embodied experiences, then any attempt to “understand human nature would have to begin with the body” (Carel, 2011: 4). Secondly, any changes to the body or to the circumstances or realities in which we experience our bodies,

(for example, in postpartum) would therefore have the effect of ‘transforming subjectivity itself’ (Carel, 2008: 13).

My position has also been informed by structuration approaches to embodiment. This is a view based on the notion that human agency and social structure are not two separate concepts or constructs, but are co-produced and mutually constituting through social action and interaction (see Giddens, 1991; Bourdieu, 1984; Grosz, 1994). Like Shilling (2003), my view is that embodied subjects both “create their social milieu, through the capacities and facilities of their bodies, and are simultaneously shaped by the impact their social location exerts on their bodies” (Shilling, 2003: 206). Finally, in line with Doucet (2006) and many other sociological and feminist writers, I argue that while the body has a “biological and material base” it is “nevertheless modified and variably enacted within different social contexts” (2006: 700). By this I mean that “the socially contingent nature of the body, and how it is experienced will vary according to how, where, and when it is located and the nature of the social situations which prevail” (Nettleton and Watson, 1998: 8).

Having discussed my main philosophical and theoretical influences, in the following section I turn my attentions to my research design, specifically my decision to use semi-structured interviews and to adopt a longitudinal approach. I also rationalise my decision to interview participants at three specific time points over the first six months of postpartum.

### **3.4 Research design and methodology**

As previously discussed, one of the central aims of this study was to explore aspects of individual experiences of health and weight management in the first six months, following childbirth. I was especially interested in exploring the day-to-day, lived and embodied accounts of large women in postpartum. Turner (1992) has argued, that the researcher, mindful of the research question, must then engage in what he calls “methodological pragmatism” (1992: 57). By this he means, that “the epistemological standpoint, theoretical orientation and methodological technique (adopted)...should at least in part be determined by the nature of the problem and the level of explanation which is required” (Turner, 1992: 57). Therefore, mindful of these aims, my epistemological and ontological position (as detailed above), my desire to focus on individual experience and the exploratory nature of this research, the use of qualitative methodology seemed an appropriate means of exploring this phenomenon.

Although there is no one definition of what qualitative research is, there is widespread agreement that qualitative research is a useful approach when attempting to make sense of and interpret phenomena “in terms of the meanings people bring to them” (Denzin and Lincoln, 2005: 3). In line with interpretivist philosophy, broadly speaking, it is also an approach that recognises and embraces the possibility of multiple interpretations of reality. Furthermore, one of the central tenets of a qualitative approach is the encouragement to look at a research project from start to finish as an inductive and emerging process; each step along the way forming and informing all subsequent steps (Maxwell, 2012). I was and continue to be endeared

to the idea of inductivity, because it is open-ended, exploratory and expansive. It is also flexible, in that it enables and offers the researcher the opportunity to revise and rethink particular aspects of the research project, without being confined to and constrained by a particular hypothesis.

I chose to conduct in-depth semi-structured interviews with my participants as these are particularly useful when attempting to understand the views, beliefs and feelings of participants (Mason, 2002). They offer participants the opportunity to explain, discuss and tease out their own ideas, and hence to display their own meanings and understandings (Barbour, 2008; Britten, 1995; Legard et al., 2003; Rubin & Rubin, 2005). In-depth interviews also enable issues to emerge from the data which may have been unforeseen at the study outset (Pope and Mays, 1995). One of the key features of in-depth interviews is that they are both structured and flexible, allowing topics to be covered in an order “most suited to the interviewee, to allow responses to be fully probed and explored and to allow the researcher to be responsive to relevant issues raised by the interviewee” (Richie et al., 2014: 184). Moreover, in-depth interviews are particularly valuable for exploring issues that are sensitive (Lee, 1993) and for enquiring into areas that may be ‘taken-for-granted’ or rarely thought about by participants.

### **3.4.1 “The long view”<sup>15</sup>**

As addressed in Chapter 2, existing research focusing on postpartum has largely ignored the temporal dimensions of this period and has tended to focus attentions on

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<sup>15</sup> Thompson, 2007.

a single ‘snapshot’ in time or appears to have chosen rather arbitrary points at which to collect data. It was in part to address these gaps in the literature that I adopted a longitudinal methodology and sought to interview women at three different time points in postpartum – at six weeks, three months and six months postpartum (I will discuss my rationale for the selection of those particular time points in section 3.4.1.1 below).

Pollard and Filer (2002) argue that longitudinal qualitative methods are particularly useful when attempting to look at the process of change as they allow us to distinguish “the enduring from the transient in social action” (2002: 7). It is in that vein that Holland et al. (2006) have suggested that, by utilising longitudinal methodology, “it becomes possible to distinguish those differences that have consequences, and how change is differentially experienced and acted on by individuals and groups” (2006: 2). Indeed, Thomson (2007) states that the “long view offered by qualitative longitudinal research offers the possibility of developing more complex and thus realistic understandings of how, and why, individuals and communities live as they do” (2007: 572). Crucially, a longitudinal approach offers the means to “move beyond the life as told to gain insight into the life as lived” (Holland and Thomson, 2009: 453). By this I mean that a longitudinal approach enabled me to explore any discordance between what people said versus what they did, and the factors that may have influenced those outcomes. This was especially useful when I was attempting to explore why individuals may or may not have adopted certain health-related behaviours, in accordance with their intentions expressed in earlier interviews.

It has also been argued that utilising repeat interviews with the same subject overtime may facilitate what Cornwell (1984) describes as a shift from more ‘public’ accounts to more ‘private’ ones. During a single interview, when participants are unfamiliar with the interviewer, they may be more likely to modify their presentation of themselves so as to produce a much more acceptable account of themselves. In contrast, ‘private’ accounts refer to more personal, honest and reflective accounts that are likely to occur when the person is comfortable (among friends or feels a sense of trust in the other person) and therefore likely to share their true feelings. Other studies adopting a longitudinal qualitative methodology have observed similar findings. Thomson and Holland (2003) for example, in a study which followed approximately 100 young people over the course of nine years, interviewing them at nine month intervals, reported that even by the second round of interviews that their participants were “much more forthcoming in their comments” (2003: 240).

#### **3.4.1.1 Key time points**

There is no consensus as to what length of time constitutes longitudinal research (Corden and Nice, 2007; Holland et al., 2006; Saldaña, 2003). In addition, there is little if any guidance in the literature as to how long the time intervals between interviews should be (Farrall, 2006). As qualitative studies by nature are explorative, Saldaña (2003) argues that the efforts to define the length of a qualitative longitudinal study from the outset are often complicated by lack of knowledge as how long it will take for change (if any) to occur. Farrall (2006) suggests that the length of the study and the distribution interviews will depend on the subject matter and the nature of the study.

Although the decision to conduct multiple interviews over time was ultimately motivated by a dearth of longitudinal qualitative research in the area more generally, the decision to interview participants at three specific time points in the first six months (six weeks, three months and six months) was a decision grounded in the existing literature and certain notable features of the postpartum period which I conjectured might impact on women's experiences of weight management during this time. To begin with my review of the literature consistently highlighted two meaningful time points; six weeks and six months postpartum, which, I speculated, could also be an interesting time to begin a qualitative investigation. For example, across the literature, the sixth week of postpartum is generally considered a significant marker for weight loss; the rate of weight loss is typically greatest in the early postpartum months (Ohlin and Rossner, 1990; Rookus et al., 1987). Also there is an assumption, often reproduced in the literature, that that women 'should' have returned or be well on the road to returning to their pre-pregnant weight status by six weeks (Olds et al., 2004). However, other research suggests that, despite this assertion, over two-thirds of women have not attained their pre-pregnancy body weight at this time (Schauberger et al., 1992; Walker et al., 2004a). If the majority of women have failed to return to their pre-pregnancy weight status, it brings into question if this is a reasonable expectation; and, it also indicates a need for additional research to better inform and support women at this point in time. I also thought that six weeks postpartum may have been an opportune time to interview women, as it traditionally marks the end of postnatal care which is routinely provided for all

women and their infants in Scotland and the UK<sup>16</sup> and, accordingly, this may have been a notable point of transition for some women.

For several reasons this study focused on six months postpartum. Although not pertinent to all women, breastfeeding in the UK is recommended until six months postpartum as ideal for both mother and child. This follows recommendations from the WHO's systematic review on the '*Optimal duration of exclusive breastfeeding*' (Kramer and Kakuma, 2002). Additionally, most of the major studies looking at postpartum weight retention have highlighted six months postpartum as a critical predictive factor for long-term weight retention (Linne et al., 2004; Rooney and Schauburger, 2002) but typically fail to indicate why it is so significant. Additionally, when I was designing the study in 2012, personal communication with clinicians working with women attending the postnatal follow-up clinic, suggested that they had observed initial weight loss among their attendees at three months postpartum only to be followed by weight gain at six months (personal communication with Dr. Fiona Denison). As highlighted in Chapter 2, a number of other studies, looking at embodiment and postpartum, have indicated that women experience the greatest body dissatisfaction at six months postpartum, suggesting "that women may no longer see themselves as being within a unique phase associated with birth, and thus may no longer consider a larger figure acceptable" (Rallis et al., 2007: 97). However, little, if anything, is known about how large women might perceive and experience their bodies at this particular point in time.

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<sup>16</sup> See NICE (2006) *Clinical guidelines and evidence review for postnatal care: routine postnatal care of recently delivered women and their babies*.



Finally, although six weeks and six months have consistently been identified in the literature as important markers for postpartum women, I hoped that by interviewing at these and an intervening time point at three months that it would be possible to capture and understand processes of change.

### **3.5 Ethics and safety**

As touched upon earlier, there were a number of significant ethical concerns for this project, over and above the typical considerations and measures taken to ensure participant safety and avoid distress, which are a common feature of research. As noted earlier, because I planned to recruit participants through the NHS, I needed NHS ethical approval to proceed. Ethical approval for this study was sought and granted by the NHS Research Ethics Committee in August 2012 (appendix 6). Simultaneously, Research and Development approval from the local NHS board was also required and was granted in November 2012. This also incorporated an NHS honorary contract<sup>17</sup> for my work in the field.

During the ethics review process the committee raised a number of ethical concerns which I will address below. The first of these concerned my access to patient files and how I would go about ascertaining whether a given woman satisfied the

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<sup>17</sup> NHS (2012) '*Research in the NHS – HR good practice resource pack*' stipulates that an honorary contract 'is required by researchers with who do not have a contractual relationship with the NHS and when the planned activities of the researcher involve interacting with individuals in a way that has a direct bearing on the quality of their care, i.e. the researcher could foreseeably directly affect the type, quality or extent of prevention, diagnosis or treatment of illness or foreseeably cause injury or loss to patients or service users to whom the NHS organisation has a duty of care. It should be noted that, an honorary research contract does not confer the right of access to confidential information for research without explicit consent' (2012: 4).

inclusion and exclusion criteria<sup>18</sup>. As a reminder, although I was permitted access to patients I was not permitted to access their confidential patient information. As such this stipulation created a number of practical issues as to how I might go about identifying potential participants when I could not directly access their information myself. I will describe the steps taken to adhere to this requirement in more detail when I discuss recruitment in section 3.5.2 below.

Secondly, as I would be approaching women in pregnancy to get their permission to contact them in postpartum with a view to participating in the study, the committee asked that I put in place a procedure to ensure that I was not contacting women who may not have experienced a successful birth outcome or were unwell. To address these concerns, when women expressed an interest in potentially participating in the study during the antenatal period, I kept a record of their name and anticipated delivery date<sup>19</sup>. Then about three weeks after their predicted delivery date, I liaised with one of the midwives at the clinic, who in turn reviewed the patient records to ascertain if there was any circumstance which would preclude me from contacting the women directly.

There were also other ethical concerns which I had given some consideration to independently of the ethics committee that are also worthy of mention. One of these centred on the use of particular terms and language to reference weight and size. For

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<sup>18</sup> The specifics of the study inclusion and exclusion criteria will be detailed in section section 3.6.2 below.

<sup>19</sup> This information was recorded on site at the specialist antenatal clinic on handwritten sheets. These were stored in a secure office at the clinic. These sheets were destroyed once I had made initial follow up calls to enquire about participation in the study.

example, in this research, I elected from the outset and deliberately so, not to use the word obese or derivatives thereof, in the title or on any of the participant information sheets, a decision which was supported by the ethics committee. The decision not to use obese was unequivocally driven by my understanding of how the word obese is socially and culturally positioned as both intensely moralising and pejorative (Saguy and Riley, 2005). Moreover, I felt that for some women the word obese could have been seen as offensive in its own right, but also, as Longhurst (2010) highlights, offensive, in that I was inviting participation in a project “on fat bodies when they (potential participants) might not perceive themselves as fat” (2010: 203). This was a dynamic which I feared could have had the double effect of not only causing upset but also could have discouraged women from participating in the study and, as a consequence, was ethically problematic.

While I took efforts to neutralise the language used in the participant information sheets, I also recognised that by linking weight with health, it could be argued, that I was feeding into discourses of “moral blame, fatness, and individual responsibility” (Warin and Gunson, 2013: 1690). Also, although women were intentionally recruited because they had a ‘high BMI’ (specifically a BMI  $\geq 40$  kg/m<sup>2</sup>) and therefore, considered in a clinical sense, ‘morbidly obese’, participants were never explicitly told why they were being recruited, beyond their attendance at a specialist antenatal metabolic clinic. None of the participants ever asked if they were being recruited to the study because they were overweight.

I was also careful about the language I used when speaking with the participants about their body weight and size. During the interviews, following Warin et al.’s

(2011a) and Monaghan's (2008) approach, I listened to how participants talked about their own bodies and the language they used when discussing their weight and size and I tended to replicate those particular terms in any further conversations. Indeed, as discussed in Chapter 1, I have very purposely elected to use the term 'large' throughout - in the title of the thesis and in the findings and discussion chapter - to reflect the most common term employed by my participants when talking about their weight.

It was a consideration prior to beginning the interviews, that talking about weight and size might have been perceived as a sensitive issue for some women and therefore, had the potential to evoke some distress. Moreover, because the interviews were semi-structured and explorative in nature I also recognised that it was conceivable that issues (personal or otherwise) may have arisen which women could have been experiencing difficulty with. For example, I considered it a possibility that some women might have been experiencing postpartum depression. Therefore, if participants raised any concerns about a health related issue during the interview I advised them to contact their local GP or to discuss their concerns with their health visitor. In the case of one participant who described feeling depressed during our second interview together, I asked her if she was receiving help and offered to look into free counseling services offered in her area. While she declined my offer on the grounds that she had planned to look into the matter herself, I did make a point of following up with her and discussing the matter with her in the subsequent interview. In addition I anticipated that there may have been a 'delayed' (McCosker et al., 2001) impact around issues that we were discussing, as such, I began each subsequent interview by asking women how they felt about the previous interview(s)

and if our conversations had raised any concerns for them which they wanted to discuss.

Apart from ethical concerns related to the participants, as the interviews took place in women's homes, often in areas with which I was unfamiliar, this necessitated that I put in place a procedure to ensure my own safety. Therefore, before each of the interviews I placed the address and contact details of the person I was due interview in a sealed envelope in a secure cabinet at my desk. I then told someone (typically a colleague in the office) that I was interviewing that day and gave a rough estimation of when I expected the interview to conclude. Following each interview I would text my colleague to let them know that I was fine. In the event that I did not contact them within a reasonable amount of time, they knew to access the information on my desk and take specific, pre-arranged steps to try and ensure that I was safe.

Thankfully, no concerns around my safety arose during the interviews.

Finally, participant confidentiality was a key factor throughout the research process and all data generated from the study has been handled in accordance with the Data Protection Act 1998. In this regard, the participant information sheet (appendix 2) also informed the participants of how I planned to ensure both their confidentiality and anonymity throughout the research process.

### **3.6 Recruitment and sampling**

#### **3.6.1 Recruitment**

As described previously, all participants for this study were recruited from a single site, located at the Royal Infirmary of Edinburgh. This is a specialist antenatal

metabolic clinic which provides tailored care to pregnant women with a BMI  $\geq$  40kg/m<sup>2</sup>. Most women in this study were referred to the clinic by their community midwife at their first antenatal appointment (approximately 10-12 weeks) when it had been established that their BMI was over 40 kg/m<sup>2</sup>. It should be noted that a referral to the clinic is simply an 'option' to attend and staff working at the clinic estimated that approximately 50% of women referred actually attended the clinic. Women are weighed and their weight recorded at every appointment. As well as routine bookings and 20 week fetal anomaly scans, growth scans are carried out at 28, 32 and 36 weeks. In addition to routine antenatal appointments, the women have access to a variety of specialists such as endocrinologists, anesthetists and dieticians. Following delivery, the women return to the clinic and are weighed and their babies are assessed at three months and six months primarily to measure that baby's growth.

I attended the specialist antenatal clinic, which ran once a week on Tuesdays for approximately five months while in the active recruitment stage. During this time the numbers of women attending varied significantly but on average approximately 10 women attended each week. The attendees included women at various stages of pregnancy, some of whom were attending for their first antenatal appointment at around 12 weeks and others who were returning for checkups. Depending on the degree of risk or complication, at the later stages of their pregnancy some women attended the clinic every week.

I initially planned to recruit women in the later stages of pregnancy at 36 weeks, as for most women this marked the final appointment before birth and therefore there would be a minimal wait time to the first interview. However, during the months I

recruited from the clinic the numbers of women at this stage of their pregnancy were low and, as such, I was forced to consider recruiting women at much earlier stages in their pregnancies to ensure I had sufficient numbers. Although this approach meant that I had access to a much larger group of potential study participants, it often meant that there were significant gaps in time between when I made initial contact with women at the clinic and our follow up in postpartum. This also meant that data collection went on for longer than originally anticipated.

Additionally, because I was restricted from accessing the participant files directly, I could not personally identify which women met the basic inclusion and exclusion criteria. Instead the midwives on duty (usually two) would review the appointment list on a particular day and identify which women met the basic inclusion criteria. Those women were then asked by their midwife – usually at the end of the consultation – whether they would be interested in learning more about an interview study looking at health and weight management in the six months after childbirth. At this point if a woman indicated that she was open to learning more about the study, the midwife would provide them with my study information pack which included a covering letter (appendix 1), a participant information sheet (appendix 2) and a copy of the consent form (appendix 3) to look over and keep. With their permission, I was then invited into the consultation room to briefly explain the study and to answer any questions or concerns arising. Crucially, women were not being asked to commit to participate in the study at this point. Instead, the recruitment system was, at this stage, concerned with finding women who would be willing to be contacted via telephone in postpartum, to discuss formally taking part in the study. If they were agreeable, I asked if they were happy to consent to give me their contact details

(telephone number) and their anticipated due date. I also let them know that I would be in contact by telephone approximately three weeks into postpartum, to establish if they were still interested in taking part.

In the five months I spent recruiting at the clinic for the study, a total of 44 women initially indicated that they would be willing to be contacted in postpartum. Of those 44 women, 13 later agreed to participate. Furthermore, two previous attendees (Bernie and Susan<sup>20</sup>), who had both given birth shortly before I started recruiting at the clinic were contacted by one of the midwives at the clinic and asked if they would be interested in receiving an information pack about the study. Both women agreed and on receipt of a study information pack, subsequently returned the study opt-in form, indicating their interest in participating in the study.

Regarding the 29 women who did not participate in the study, 22 of these women either declined to participate, felt they were unable to participate (due to a host of personal reasons), failed to return my calls or, in the case of one woman with whom I scheduled an interview, she was not at home at the arranged time and did not respond to my further attempts to contact her. Furthermore, because I had made the decision to recruit women at various stages of pregnancy (as opposed to from 36 weeks which had been the original plan), seven women had not yet given birth towards the latter stages of data collection phase. Given the longitudinal nature of the project and certain time restrictions imposed by the PhD itself, I elected not to approach these women with a view to participating in the study. These women were subsequently notified and thanked for their willingness to participate.

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<sup>20</sup> Pseudonyms



In total I interviewed fifteen women and conducted forty-two interviews. The original plan for the study was to interview each participant three times. However, one of those women (Salma) did not return my calls after the first interview and I was unable to schedule any further interviews with her. Also, another participant, Jane, who I had successfully interviewed twice, was in the process of moving house around the time of our final interview and after a number of unsuccessful attempts to find a time to meet, she finally acknowledged that she felt she was too busy to continue with the study. Nevertheless, I decided to include their interviews, although incomplete, I felt they provided valuable information for the study.

### **3.6.2 Sampling**

I employed a purposive sampling strategy (Mason, 2002; Patton, 2015) to identify participants for this research project. Richie et al. (2014) suggest that purposive sampling is not intended to be statistically representative but that individuals are deliberately chosen because they have “particular features or characteristics which will enable detailed exploration and understanding of the central themes and puzzles which the researcher wishes to study” (Richie et al., 2014: 78). Women were eligible for inclusion in this study if they had attended the specialist antenatal metabolic clinic, had a body mass index (BMI) of  $\geq 40 \text{ kg/m}^2$ , had a successful birth outcome, spoke English and, for ethical reasons, were over the minimum age of consent, which is 16 years of age in Scotland.

Given the exploratory nature of the research and the dearth of research in the area as a whole, I felt it was both unnecessary and perhaps unhelpful to further differentiate the study sample. Therefore, the sample was deliberately broad, by this I mean I did

not sample for age, parity, ethnic background or class/socio-economic background. I felt that this was important as an over reliance on variables can have the effect of constraining “the possibilities for theoretical and analytic advances in the research” (Emmel, 2013: 51). Therefore, I simply looked at the initial sampling criteria as a ‘starting point’ and was mindful to avoid the pitfalls of what Mason (2002) calls ‘slippage into a representational logic’ (2002: 131).

The women I interviewed (see more detailed overview of the study sample in section 3.6.3 below) ranged in age between 21 and 41 at the time of the first interview. Just under half of the participants (n=7) were first-time mothers, and although not an intentional sampling strategy, nevertheless, I have drawn on such distinctions in my analysis, at those times where it has emerged from the data as a significant and interesting point of comparison.

Finally, although I had initially considered the idea of recruiting women for the study from lower socio-economic backgrounds<sup>21</sup>, very early on I struggled as to how best to go about differentiating those women from others who attended the clinic.

Although, I recognise that there has been extensive research which has made strong correlations with class/socio-economic background and health, I found class categories difficult to assign and far from straight forward. Further complicating matters, was the fact that for reasons of confidentiality, I was not privy to these women’s personal information until after they consented to participate in the study in

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<sup>21</sup> As discussed in Chapter 2, most of the research to date looking at postpartum has tended to focus on women from middle-class backgrounds and as such little is known about how women from lower socio-economic backgrounds experience their health and manage their weight during this particular point in the life course.

postpartum. As such, I would have to make initial assessments of socio-economic status largely based on postal code and I was aware of concerns around doing that (Tunstall and Lupton, 2003). For example, I considered using an area deprivation index, such as The Scottish Index of Multiple Deprivation (SIMD). This is a measure that is widely utilised in health research to describe small area concentrations of material deprivation and to identify health inequalities. Some of the criticisms leveled against the use of SIMD is that many disadvantaged individuals live in areas that are not particularly deprived in terms of SIMD, moreover many individuals living in areas identified as deprived by SIMD may not be particularly disadvantaged. I also noted these incongruities in my own sample, where there appeared to be significant diversity in my participants' life circumstances, which often appeared to be independent of postal code. A pertinent example is provided by Caroline, who had attended college and received a university degree, yet lived in an area which would have been considered 'deprived' by SIMD.

### **3.6.3 The participants**

In the table below I have provided some basic demographic details for the women I interviewed. I have included their pseudonyms, age, number of children, ethnicity, marital status, level of education, occupation, if they had a caesarean birth, if they breastfed and for how long, and finally, if they had a diagnosis of GDM during pregnancy.

In many respects the sample was quite diverse with the participants ranging in age from 21 to 41 years of age. The sample was less diverse in terms of ethnicity and nationality, with the majority of participants being white and British (12

participants). The exceptions were Mel who defined herself as white and North American, Salma who was from Pakistan and of East Asian ethnicity and finally, Harjeet who was Scottish and also of East Asian ethnicity. Seven of the sample had graduated from high school, a further seven had university degrees and one participant, Alice had a Higher National Diploma from a local community college. The section on occupation gives some indication of socio-economic status, although for reasons stated previously (see Section 3.6.2), due in part to a miss-match between occupation and the realities of individual life circumstances, I have been reluctant to assign particular class categories. With this in mind, in addition to the table below, I have provided short portraits (see Appendix 7) for each participant detailing the particulars of their life circumstances.

**Table 2: Overview of the study participants**

<b>Name* age)</b>	<b># of children</b>	<b>Ethnicity</b>	<b>Marital Status</b>	<b>Occupation</b>	<b>Education</b>	<b>C-Section</b>	<b>Breastfed</b>	<b>GDM</b>
Susan (33)	1	White/UK	Single	IT	University Degree	Yes	No	No
Sarah (25)	2	White/UK	Single	Long-term unemployed	High school	Yes	No	No
Lisa (31)	1	White/UK	Married	Full-time Student (UG)	University Degree	No	Yes (5 ½ months)	Yes
Mel (35)	3	White /North American	Married	Part-time Student (UG)	University Degree	No	Yes (6 months)	Yes
Jane (30)	4	White/UK	Married	Clerical	High school	No	No	Yes
Bernie (41)	3	White/UK	Married	Clerical	University Degree	No	Yes (6 months)	Yes
Salma (21)	1	South- East Asian	Married	Sales	High school	No	Yes (2-3 weeks)	No
Tara (26)	2	White/UK	Divorced	Full-time carer	High school	No	No	No
Liz (31)	2	White/UK	Married	Teacher	University Degree	Yes	No	Yes
Alice (28)	1	White/UK	Married	Health worker	Higher National Diploma (HND)	Yes	Yes (2 weeks)	No
Harjeet (31)	3	South- East Asian	Married	Tourism	High school	Yes	No	No
Caroline (32)	1	White/UK	Partnered	Clerical	University Degree	Yes	No	No
Emily (33)	1	White/UK	Married	Civil Service	University Degree	No	Yes (6 months)	No
Alison (33)	5	White/UK	Married	Postal Service	High school	No	Yes (3 months)	No
Donna (29)	1	White/UK	Married	Retail Manager	High school	Yes	Yes (3-4 weeks)	Yes

\* All of the names are pseudonyms.

### **3.7 Interviewing**

#### **3.7.1 Scheduling the interviews**

As highlighted previously, women who expressed an interest in participating in the study in pregnancy were then contacted by telephone at approximately three weeks following the birth of their child. During these follow up conversations, I began by briefly reintroducing myself and reiterating the purpose of the study. I also emphasised that involvement was voluntary and that there would be no repercussions should they decide not to take part, or if they decided to drop out at a future date. Indeed, McLeod and Thomson (2009) argue that in longitudinal research, participant consent should be considered provisional and continuously open to renegotiation (McLeod and Thomson, 2009). In this vein, I stressed the voluntary nature of the research when scheduling all subsequent interviews and reminded women that they were under no obligation to continue to be involved.

Once a woman had formally agreed to participate in the project, we then went about agreeing upon a location, date and time for the first interview. Although I anticipated that I would be interviewing participants in a variety of settings and participants were given the opportunity to decide on the location of the interviews, all of the women in this study chose to be interviewed at home. Indeed participants indicated that this was highly preferable given the often unpredictable nature of their days and some of the practical challenges many described experiencing when trying to leave their homes and/or travel with the baby. The presence of the baby not only impacted on the interview location but also had significant implications for the interviews which will be discussed in more detail in section 3.7.2 below.

Once a time and location for the initial interview were established, I then sent a text reiterating those details. Participants often commented that this was hugely helpful, as many joked that they had ‘baby brain’ or that they felt so sleep deprived during the early stages of postpartum that they had difficulty remembering appointments. Again, the day before the scheduled interview I sent a further text, providing the previously agreed upon details of our scheduled interview. At this time I also offered participants the option to reschedule the interview if there was any reason they felt they needed to. On a number of occasions participants did avail of the opportunity to do so, usually because the baby was ill or particularly unsettled that day or week and, in the case of one woman, Caroline, a death in the family necessitated that we postpone one of our interviews for a week. I also felt this kind of flexible approach was a useful strategy as it helped to ensure that participants continued to participate in the study, rather than feel the need to drop out.

Whilst the initial interviews were scheduled over the phone, for the most part all subsequent interviews were scheduled by text. Again this seemed a highly effective means of communication for this group of women, given the busy nature of their lives, they could respond to texts on their own terms.

### **3.7.2 The process of the interviews**

The interviews were guided by a topic guide (appendix 5). This consisted of a series of prompts based loosely around subjects I was interested in exploring with the women. As the interviews progressed, however I found myself modifying and altering these, often in response to issues or to accommodate interesting themes which had arisen in other/earlier interviews. For example, when I initially I designed

the topic guide I had planned for a more extensive investigation of the physical environments, neighbourhoods etc. and ultimately how these environments may or may not have impacted their engagements with physical activity. However after the first three or four interviews, it became clear from the participant responses that this was not a topic that resonated with them. Although, I did raise this as a topic in subsequent interviews, it featured less significantly in the interviews.

As one of the aims of this research was to explore change over time, this necessitated that certain subjects (related to eating and physical activity for example) were explored in every interview, but there were also certain issues which I decided to focus on in particular interviews, over others. There were a number of pragmatic reasons for this decision. For example, I tended to begin the initial interview with a series of closed-ended questions to collect socio-demographic data before moving on to more open-ended questions. This also appeared to be a gentle way to ease into the interviews. I also tended to use the first interviews to explore their experience of pregnancy, their feelings about their attendance at the clinic and their food choices and activity behaviours during pregnancy. My decision to focus on pregnancy primarily during the first interview was simply because I felt that these experiences were likely to be fresh in their minds but I also wanted to collect contextual information which I felt would be useful in understanding their subsequent postpartum experiences. Also, these were topics of discussion that were not necessarily revisited in subsequent interviews – unless women chose to bring them up or I felt it was pertinent to revisit them.



Moreover, following my first two or three interviews, I began to notice a trend: the interviews were typically restricted to an hour and usually on the grounds that the baby needed to be fed or became ‘gurney’ (unsettled). Indeed, it was rare for an interview to go by without being ‘interrupted’ by a crying baby, needing to be fed, changed, played with or comforted, indeed perhaps all of these things. More often than not, I played a role myself in entertaining the baby or holding the baby while the mother briefly attended to something, - it was simply an unavoidable ‘inconvenience’ in the interview process. As a result, questions often went unasked (needless to say, where possible these were reworked into subsequent interviews), and answers were interrupted as interviews were paused or curtailed by a baby in need of attention. Thomson (2012) highlighted similar challenges and commented on the “practical difficulties” as the “interviewer and interviewee struggled to recapture the kind of quiet reflective space” deemed necessary for a productive interview:

Babies were often around during the interviews conducted one year after birth, and interviewer and interviewee struggled to recapture the kind of quiet reflective space that had previously been possible in one-to-one interviews. Conversations tended to be arranged so that the mother was able to ‘escape’ the child for long enough to talk to the researcher, but were frequently curtailed by interruptions. Our field notes for these interviews are infused with the presence of the child and our attempts to negotiate space to speak directly to the mother (2012: 188).

As such, I made the pragmatic decision to ‘spread out’ certain topics over the three interviews, to try and ensure that the interviews did not run too long. Finally, there were a number of topics which I had anticipated from the outset might have been more challenging to discuss than others, for example, one area I was interested in exploring with women was their feelings about their children’s weight and size. As

such, I felt it would be better to explore these issues in later interviews when I anticipated we were more likely to have established a rapport.

In general, the interview questions included appropriately framed and targeted questions to gather data on women's perceptions and attitudes towards their body weight, weight management (diet and physical activity) and lifestyle change in the postpartum period. I typically began follow up interviews by asking women more generally to describe how their life had been since the previous interview. Not only did these interviews explore continuity and change between time points, the second and third interviews also allowed me to revisit, expand upon and more fruitfully explicate particular topics which may have been only given cursory attention in previous interviews. I also asked questions in an effort to explore the context in which women lived their lives, by this I mean I attempted to explore how they felt about their neighborhoods, if they felt safe and able to walk around etc. I also spent some time familiarising myself with the areas in which women lived, which I felt was a useful strategy. For example, on a number of occasions I noticed the absence of footpaths, which I perceived as potentially problematic when walking with a pram. Although not sharing my concerns with the participant directly, having such knowledge at times helped to facilitate more focused questions.

### **3.8 Making sense of the data**

#### **3.8.1 Transcription**

All interviews were audio recorded and transcribed verbatim. I transcribed the majority of the 42 interviews, however towards the end of the interview stage, in the interest of expediency, six of the interviews were transcribed by a professional

transcriber. Afterwards, I listened to the audio recordings of those particular interviews again and checked the transcriptions against the recordings to ensure accuracy. Indeed, I found listening to the audio files an invaluable step in the process of analysis. Not only did I jot notes along the way as I listened, I also found listening to the interviews afforded me the opportunity to relive and revisit the interviews in a very real and tangible way, which I found immensely beneficial.

As far as possible I attempted to stay true to the particular language and colloquialisms used by the participants but I recognise that although transcription is often presented as a “behind-the-scenes task” (Oliver et al., 2005: 1273) that it is far from neutral (Mason, 2002). For example, I made some decisions along the way which affected how the quotes are presented in the findings chapters. In the original transcripts I noted any pauses in conversation but when using quotes in the findings chapters, I have removed these pauses, as for the most part I felt they unnecessarily distracted from the flow and meaning intended. Only when I felt such detail was significant to the conversation overall have I elected to retain and note pauses. In addition, any utterances made by myself and inflections, such as ‘em’, ‘right’ and ‘okay’, (as is a common feature of conversation), were recorded as separate remarks in the transcripts, and again, unless important or when showing a lengthy extract of dialogue, I have omitted them. In the instances where text has been removed, I have indicated this by means of ellipsis (...). Moreover, I have labeled quotes by noting the interview round (1,2 or 3). This information is more pertinent at certain times over others, however for consistency’s sake I have chosen to adopt this practice throughout.

### 3.8.2 Coding and analysis

Although I recognise that analysis in qualitative research is not a discrete phase of the research but occurs throughout the research process (Coffey and Atkinson, 1996), in the following, I explicate some of the more notable aspects of what I describe as the more ‘formal’ analysis phase. To begin with I found the analysis an extremely challenging endeavor. Having little practical experience on how best to approach qualitative analysis when I began this project, I was both excited and daunted by the prospect. As I read more about ‘doing’ analysis, it seemed that constructivist grounded theory offered by Charmaz (2006) would allow me to overcome some of my uncertainties, as it purported to offer a detailed and systemic approach from which to structure my analysis. It is also an approach which is ‘grounded’ in the views and experiences of participants, rather than a preconceived hypothesis (Creswell, 2013: 13) and, in this way, it complemented my study aims very well. In theory, it also seemed to provide a robust framework and structure to my analytical conundrum – how best to manage and make sense of the overwhelming amount of nuanced data, longitudinal qualitative interviews typically yield.

Once I had about six interviews I decided to try to begin coding using NVivo (a data analysis software package). Initially, I followed Charmaz’s (2006) approach to qualitative analysis and I began by coding the interviews ‘line-by-line’ (using both descriptive and thematic codes) (2006: 50). However, this yielded a proliferation of codes in excess of a 150 per interview. As I attempted to collapse and condense these codes into a more manageable form, I became unsure as to what codes I should keep and those I should let go of (Kelle, 2007). I also found myself stuck somewhere

between the remit to allow the theory to emerge from the data (which it very obviously was not doing) and my hesitancy to introduce theoretical knowledge from the literature, lest I unduly influenced the findings. Instead of this process bringing me closer to the data, it had the opposite effect of pushing me away. In colloquial terms, I felt the interviews and participant accounts were not afforded the opportunity to breathe<sup>22</sup>, so encumbered were they by the analytical paradigm bearing down upon them. Over and over, I felt the remit to code, micro code, from which one could then create ‘tidy’ matrices, which in turn would bear a shared set of thematic elements, overbearing. The cleanly, ‘cut up’ and fragmented participant accounts, grouped together thematically brought with it a certain deadness to the lived accounts, lying as they did on the pages in front of me, stripped of much of their contextual meaning. Riessman (1993) describes a very similar experience and her struggle to code participant experiences using more “traditional qualitative methodology” (1993: vi). She goes on to describe how her participants’ accounts, which were often long and meandering, resisted “easy categorization” as they tended to touch on several themes at once. These themes were ‘knitted’ and overlapping in complex ways and, as such, she struggled to “fragment the long accounts into distinct categories” (Reissman, 1993: vi). Implicit here, is the notion that, something fundamental is lost in the act of dividing and fragmenting; something of the individual’s account is irreparably lost.

After discussing these concerns with my supervisors, I decided to stop coding in this manner and instead returned again to reread the transcripts and revisit the literature, which I hoped would help me to try and gain a better understanding about what I was

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<sup>22</sup> I employ the term ‘breathe’ here in the metaphorical sense, drawing loosely on Arthur Frank’s (2010) work *‘Letting stories breathe: a socio-narratology’*.

seeing in the accounts. To be clear, I am not discounting constructivist grounded theory as an approach to analysis, but as my analysis progressed I felt compelled to adopt a more ‘pick and mix’ approach. To overcome some of these analytical challenges, I began to look once more to the literature and drew from a host of academic traditions. Like Maxwell (2012), I too had become “skeptical” of the use of a single “paradigm” in my approach to my analysis (2012: vii).

After my initial, largely unsuccessful foray into coding, I decided that it would be helpful to write interview summaries for each of the participants, and, as the interviews accumulated for each individual, I was then able to add to and update those summaries. I found this a useful activity as not only did it allow me to become more familiar with the data, but the process helped me to build a much clearer picture of each participant’s story over time and had the added effect of maintaining the integrity of the accounts by keeping them together. Writing the summaries also encouraged me to begin thinking about broad themes but also prompted me to begin to become more focused.

Alongside the participant summaries I also made extensive notes, loosely based on what Charmaz (2006) calls ‘memo-writing’. She describes these as a way of “developing ideas”, making comparisons and connections and the means by which one can “crystallize questions and directions” for the researcher to pursue (2006: 72). While writing these memos, I also delved extensively into the literature and established a very broad coding framework. I began by creating more general categories such as ‘experience of pregnancy’, from which I created further sub-categories such as ‘diet’, which were further differentiated into codes like ‘eating for

two' and 'control'. Gradually over time, with extensive writing, revisiting the transcripts and the literature, the themes which emerged from the analysis became much clearer and well defined.

Throughout all of this I was mindful that I also needed to make sense of my participants' accounts over time, but I also found that there was little consensus as to how longitudinal qualitative research analysis should be undertaken (Lewis, 2007). Nevertheless, I decided to approach this task in two ways. Firstly, although I had been creating and building on the participant summaries throughout the interview process, once all of the interviews had been completed I felt it necessary to go back again and read each of the three transcripts for one person, consecutively in one sitting. I felt this was necessary to really get a sense and feel for change over time (or lack thereof). I also attempted to address change over time by following the analysis suggested by Holland et al. (2006), in which the data is analysed longitudinally and cross-sectionally. Following this approach I looked at each data set at a specific time period, in this instance at: six weeks, three months and six months. Secondly I looked at the data cross-sectionally by focusing on changes between the three time points for each individual. Lastly, the third stage and final stage of the analysis involved a thematic analysis (Braun and Clark, 2006) in which I attempted to focus specifically on change over time; in other words, looking at themes identified in baseline interviews and comparing those to the themes identified in subsequent interviews.

### **3.9 Reflexivity**

#### **3.9.1 There is no “view from nowhere”**

The title of this section is derived from Riessman’s (1993) discussion of Nagel’s (1986) work, *The view from nowhere*. I have appropriated the term here in acknowledgement of my own belief that, as researchers, we bring with us certain pre-conceptions, experiences, and histories, which knowingly and unwittingly inform our position or ‘view’. These views and experiences are often positioned as having a potentially deleterious effect on the qualitative research process and the ‘quality’ of the data produced (Glaser, 1998). As such, qualitative researchers are increasingly encouraged to be reflexive and acknowledge our presence and how who we are affects the data we collect and interpret. Mason (2002) suggests that being reflexive involves making the research process itself the focus of analysis, a feature of which involves acknowledging and continually re-examining how a researcher’s own experience and social position may affect the research. To be clear, this is not done with the explicit intention of leaving such experiences behind or to the side, but is an attempt to be mindful of the circumstances in which the data and knowledge produced come about. With this in mind, I wrote extensive field notes after each of the interviews where, among other things, I deliberately attempted to unpack my own thoughts and opinions concerning different subjects as they arose in the interviews. Moreover, in an effort to resist making tacit assumptions, as the research process became more familiar and therefore less ‘exotic’, I also kept a research journal throughout this project. In this, I wrote about and actively reflected on my experiences, certain choices I made, various challenges I encountered and my



thinking at particular points during this project. Not only did the field notes and the research journal serve as important reflexive tools which helped to make the process more “transparent” to me (Ortlipp, 2008), but they were also useful activities in helping to develop and refine my thinking around many aspects of the research. For example, both were instrumental in encouraging me to think about the analysis, as I reflected on particular themes as they emerged, even during the very early stages of the research. As a consequence, this facilitated an inductive process whereby I made amendments to the topic guides, for example, in order to explore certain emerging issues in subsequent interviews.

I acknowledge that the interviews themselves and the knowledge produced were very much a product of the unique, situational dynamic between the participants and myself. As such, I recognise that the interviews I conducted represent a “construction or reconstruction of knowledge more than excavation of it” (Mason, 2002: 63) and that, in other circumstances and/or in the presence of a different researcher, the knowledge produced might have been markedly different. That said, although I acknowledge the constructed nature of ‘truth’, this “does not negate the possibility that the interviews can generate meaningful insights” (McLeod and Yates, 2006: 83). I agree with McLeod and Yates who observe that “refusing the possibility of full truth does not cancel meaning, does not remove the possibility of learning something new, of gaining insight while being mindful of the construction and limits of the research encounter” (2006: 83).

Finally, I would like to draw attention to and consider how my own body potentially affected the interviews. Much has been written about the appearance of the

interviewer, for example, how their gender, ethnicity, body language, age, and social status can impact on the interviews themselves (Stanley and Wise, 1993). Beyond those concerns, given that I was exploring topics around body size and weight, I was conscious that in this sense my own body was significantly different from those I was interviewing. Although I am not ‘skinny’, I have spent much of my adult life engaged in vigorous physical activity and typically have had a BMI which would be considered to be within the ‘normal’ range. Although, none of the participants ever discussed or made reference to my weight or size, it is nevertheless likely that my appearance had some influence on the interviews. As I will go on to show in Chapter 4 this seemed like a logical assumption as my participants often made notable references to the body size and weight of others, which played a role in informing how these women experienced and made sense of their own bodies and health.

### **3.9.2 Exploring embodiment: challenges, dilemmas and reflections**

Finally, I would like to conclude this chapter with some of my reflections on the embodied aspects of participants’ accounts. To begin with, a key concern of mine throughout this project revolved around how to refer to the body in my written work. In particular, I was keen to try and acknowledge the influence of phenomenology and to avoid inadvertently reiterating and reproducing mind-body dualisms by talking about ‘the body’. Indeed, Weiss (1999) suggests that to write about the body is a “paradoxical project”, and that in making the body a “discrete phenomena of investigation” or referring to it as a “singular entity” that we may be in danger of losing sight of the fact that the body is “never isolated in its activity but always already engaged with the world” (Weiss, 1999: 1). Not only is the expression ‘the

body’ problematic insofar as it implies “discrete phenomena that are capable of being investigated apart from other aspects of our existence to which they are intrinsically related”, but also the use of the “definite article suggests that the body and the body image are themselves neutral phenomena” (Weiss, 1999: 1-2). To overcome this conundrum, I have decided to follow suit with Doucet (2013) and have chosen to use the terms “body and embodiment interchangeably” (2013: 286). I felt in doing so I would not only escape reproducing dualist tendencies but also avoid the implication of a “social constructionist approach” (Doucet, 2013: 286), which it has been argued can have the “the effect of erasing the materiality of human bodies” (Shilling, 2012: xvii).

As I have suggested previously, I was also interested in looking at how these women experienced their bodies. However, a concern which was raised at my first-year review and one which is echoed by Doucet (2006), centred on the notion that embodied “experience and subjectivities are not completely accessible to researchers” (2006: 699). Although I tried to focus my attentions to ‘how’ my participants went about articulating their embodied experiences, nevertheless I encountered significant challenges getting people to talk about their bodies. For example, throughout the interviews there were few overt and explicit references to the body and more often my specific questions aimed at exploring aspects of embodiment failed to strike a responsive chord with participants. Lawler (1991) too, in a discussion of the methodological challenges in her study which explored nursing and the ‘management’ of the bodies of others, in particular the “intimate aspects of other people’s bodies”, discussed the difficulties inherent in researching phenomena which is “familiar” and which we have come to learn “to take for granted” (1991: 5).

Lawler, who trained and worked as a nurse described that state of knowing something, of being so familiar with something, yet finding that she “knew about these things in a way which had not yet been translated into language” (Lawler, 1991: 5).

We can see strong parallels to this study, particularly in the instances where women were explicitly asked to discuss their bodies, and often struggled to respond, and/or did so in a manner that I can only describe as inability to find language. For example, some participants alluded to the ‘taken-for-grantedness’, indicating that they had “never really thought about it before”. Despite the some of the challenges I encountered around getting participants to talk about their bodies, their bodies emerged in different ways. There were, for example, long and meandering accounts of daily care-taking and work related tasks, which inherently involve use of a ‘body’ to do things, the juggling of childcare activities with other aspects of daily lives, which filled the interviews. Initially, I attempted to escape this dialogue and strategies to ‘steer’ the interviews in other, more interesting and purposeful directions, for example to explore aspects of large embodiment, but as a strategy this had often proved rather fruitless. With the assuredness that a stretched spring will recoil back to its original place, the interviews always returned to the everyday and commonplace activities that I have come to know and identify with mothering. It is perhaps not de rigueur for a researcher to admit, but when transcribing and reading these particular aspects of the interviews I often found myself jaded with the content and with the frequency and regularity with which these types of discussions were reproduced – Where was the good stuff?

As discussed previously, like Thomson (2012), initially I looked at the constant interruption arising from a baby in need of attention, as an inconvenience, a distraction and ultimately an element which was at the very least, an unavoidable consideration when conducting research with mothers with young children, which at worst weakened my study. Or did it? Thomson (2012) described attempting to overcome these challenges by incorporating an observational element to the data collection to “embrace the complex relationality of the mother’s new environment” (2012: 188). The similarity of our experience notwithstanding, it is here that our two paths diverge and that divergence can be best seen in how we have chosen to conceive and conceptualise what those challenges meant in the broader sense, that is, beyond the bounds of research methodology. After some time considering this quandary, I began to see the interruptions and the constant need for adaptation and responsiveness in a different light and that perhaps I needed to ‘reframe’ how I had conceptualised the ‘problem’. Perhaps the challenge here was to make the ‘familiar’ and hence seemingly ‘banal’, ‘exotic’.

What I came to realise was that the interviews were capturing, not only dialogue but the practical (very embodied) realities of mothering a small baby– rather than a failing of research methodology, it served to re-orientate my thinking around mothering, which I could now see was a profoundly and inherently an embodied activity. Although the notion of embodiment appeared (initially) relatively silent in my readings of the interview transcripts and I had begun to think of the body and embodiment, as that oft-cited and even clichéd ‘absent presence’ in sociological tradition. Had I failed to ask the right questions to really draw out a thick description of embodiment? Was it the case that the body was not a particularly salient issue for

these women after all? However, when I returned to look at the transcripts and the lengthy discussions around the daily activities of mothering, which I had previously looked at as discrete and disparate activities associated *with* mothering and care-work, all I could see was the body. It was here I suppose I experienced a breaking down of that “familiar acceptance” which Merleau-Ponty (1962: xv) speaks of. The body, which had previously been confined to the realm of direct questions and explicit utterances, had finally emerged in all its implicitness, creating a glorious cacophony of sound.

### **3.10 Summary**

In this chapter, I have described my research process, discussed my philosophical and methodological influences and how those in turn influenced certain decisions I made. I also paid attention to and highlighted particular ethical concerns around this research, and, finally, I have reflected on some of the challenges and dilemmas I encountered when attempting to explore notions of embodiment. In the following section, as a prelude to the findings chapters, I begin with a descriptive vignette of one research participant, in an effort to set the scene and tenor for much of the ensuing discussion.



## Vignette

I have used a vignette here with a view to contextualising the findings chapters, and to introduce themes which thread through the majority of accounts. The vignette presented here not only features verbatim dialogue but also attempts to evoke something of the interview topography - that is, it incorporates descriptions of the contexts and some of my own personal reflections and feelings surrounding these encounters with my interviewees. I felt it important to write myself into the analysis, both as a researcher and engaged participant, in an attempt to (re)capture the ‘spirit’ of the narratives that the participants and I had created *together*. Indeed, Gadamer et al. (2004) suggests that conversation “has a spirit of its own and the language in which it is conducted bears its own truth within it – i.e., that allows something to “emerge” which henceforth exists” (2004: 385).

The excerpt below is taken from a series of interviews with Susan, a first-time, single mother. As is the subjective and individualised nature of experience, not all aspects of her account are typical of the group. For example, Susan’s pregnancy was unplanned, she lived alone and the baby’s father was largely absent – this was a situation not shared by anyone else. Nevertheless, as a researcher and participant, over the course of the three interviews we developed a strong rapport and, consequently, this led to particularly open, frank and insightful discussions. Furthermore, Susan was the first person I interviewed for this project and, as such, many of my initial thoughts and the direction this research took emanated at least in part from her accounts. Therefore, it seemed fitting that we begin here:

I slowly climb the icy steps to the second story flat, which overlooks a grassy square of a small, depressed mining village in eastern Scotland. It looks, I



think, particularly bleak on this unseasonably cold December morning. I am about to conduct my first in a series of three interviews with Susan, a 33 year old, single mother of one. She has given birth to healthy baby boy, just shy of six weeks previously, and I am keen to gain an understanding of aspects of her lived experience as a large woman and her attitudes towards health, at this point in her life. In truth, this is the first research interview I have ever conducted and, with each tentative step, I become increasingly aware of a sickly feeling of nervous anticipation rising up within me. Any further thoughts are however abruptly dispelled, as the door above me swings open unexpectedly. In hushed tones I am beckoned inside and ushered down a narrow hallway towards a small sitting room. Shutting the door gently behind her, Susan quietly and apologetically introduces herself and explains:

“I dinna want to wake the wee boy, he hasna had a proper nap in a few days.”

And, so Susan’s story begins.

In some sense too, our story begins.

When I leave her an hour or so later, I am not all together convinced that the interview has gone particularly well. I attempt to take stock on the journey home and later in my field notes reflect on what I felt was Susan’s propensity towards conservative answers and a hesitancy to expand and offer up details about certain aspects of her life. In particular, I reflect on a general feeling of uneasiness around discussing her weight.

Hers. And mine.

It is not until sometime later, with the benefit of hindsight and an accumulation of interviews that I can begin to understand that the subtleties and nuances of our interview dynamic were not just the product of our burgeoning relationship or my inexperience as a researcher necessarily, but valuable in their own right. That is, they were directly related to the stigma associated with overweight and correspondingly, how people talk about weight and body size.

Over the course of our three interviews, I discover that there are many ways in which Susan embodies the negative discourses around overweight and that they are not necessarily obvious nor are they immediately apparent. I begin to notice certain absences in her accounts. There are for example, words she never says: Words like ‘fat’ and ‘obese’.

There are also words she does say, certain phrases, which she repeats, time and time again. Phrases, which I’ve become so accustomed to, that when she begins:

“As I’ve said...”

I find myself quietly anticipating and it is as if we chime together like old friends in a familiar chorus:

I’m a big eater not a rubbish eater

“I’m a big eater, not a rubbish eater”

I estimate by the third interview, that this is perhaps the sixth or seventh time she has said this over the course of our time together. I have come to learn that this is important in terms of how she understands her weight and how she chooses to present this to me. Each time she says it, she attempts, I think, to distance herself from the obesity discourse she must readily encounter: Fat people eat bad foods. That’s why they’re fat.

But, Susan says she doesn’t do that.

It is on one of these occasions that I ask her why she thinks she is the size and shape she is.

She begins this particular conversation by telling me that she’s not under any “false illusions”: “I’m not saying it doesn’t help what you’re eating, but I think a lot of it is in your genes.”

She goes on to describe being on a holiday with a friend a couple of years previously. From the way she talks about it, I envisage it to be an all-inclusive, somewhere warm and sunny.

“We ate everything the same that week”, she says, “and yet, I came back and I had put seven pounds on, while she had put a pound on in our weight class”.

It’s a gene thing.

“It’s your metabolism and everything like that...my dad’s heavy and my mum was heavy when she was younger”

She’s prone to being fat. It runs in the family.

There are also topics she doesn’t discuss, at least not initially. There are subjects and issues which reveal themselves evolving slowly over time and inadvertently.

For example, she gives little indication in any of the two previous interviews that she herself had experienced any stigma or unpleasantness associated with being large and it is not until our final interview, when I ask whether she has given any consideration to the fact that her son might grow up to be overweight, that she explicitly and directly engages with her own, largely negative experiences of being overweight.

As a child, she says, there was always talk of diets and a pressure on her to lose weight. She has she says been dieting all of her life with varying degrees of success but she adds she is resigned to the fact that she is never going to be skinny. As a kid she remembers feeling a great deal of resentment and of feeling unloved. In particular, Susan's grandmother had frequently admonished both her and her mother when she received treats. Now, as a mother herself, this past experience has both informed and strengthened her resolve that her son would avoid such unpleasant experiences:

"I just wouldn't want him to be heavier because I know the down sides of it, I have lived it and so you're hoping..."

She feels a certain "pressure", she says, about being a large mother:

"I think because I am heavier and have been heavy all my life, there is a bit of peer pressure, not peer pressure but what people think. Like, if I'm in the shop and if I were to buy him a pack of sweets, that people will be like 'oh! she eats rubbish and he eats it!'. Do you get what I mean? And it's maybe the one treat he's had that month. So, I suppose there is that bit more pressure..."

I ask her if this annoys her. The idea that others may be watching her and imputing judgments about her size and her ability to mother well.

It does.

She elaborates: "Even from a personal point of view see when you get your time of the month or something like that and you have a wee sweet tooth and I really want a bar of chocolate and if I go into the shop to buy the chocolate and nobody else probably thinks anything of it, but I think, they're thinking, 'that's the last thing she needs is a bar of chocolate', do you know."

In that moment, I find myself musing on the visibility of fat. A corporeal prominence encumbered with so many moral values. I can vividly picture her at the shop counter of her local supermarket, which I have just visited, buying a bar of chocolate. Perhaps the chocolate lays partially obscured by a number of other household items, its leaden meaning momentarily disguised and with any luck it will go unnoticed. I wonder if the transaction is in any way hurried, as she attempts to escape any lingering thoughts others may have of her.

I am drawn back, as Susan laughs at herself, shifting in her seat, perhaps a little uncomfortable that she has let me in on her inner monologue. But it does challenge and push her, she reiterates. The thought of what others think, particularly, since the birth of her son:

“I don’t know before I had him I wouldn’t have cared about what anybody else said but when it comes to your child you do a bit, you don’t want people to think that you’re not doing the best for your child if ya like.”



## **Chapter 4: Making sense of body size and weight**

### **4.1 Introduction**

In this chapter, I explore how the women in my study conceptualised and accounted for their body weight and size, framed against a wider social context which routinely pathologises, demonises and stigmatises ‘fatness’ (see also Carryer, 2001; Puhl and Heuer, 2009). I will argue throughout this chapter that the manner in which these women spoke about their weight and size reflected an internalisation of wider discourses, which these women appeared to be continually conforming to and resisting, often simultaneously. Against this backdrop I begin this chapter by addressing some of challenges I experienced in the interviews when attempting to raise topics related to weight and body size. From there, I go on to discuss how these women conceptualised ‘fatness’ broadly speaking, why they employed certain terms over others and how personal understandings of weight seemed to be informed, understood and legitimised by comparisons made with other bodies. Finally, I look at how these women understood the geneses of their particular body size and the factors that they perceived as significant in influencing and determining their weight.

### **4.2 Talking about the ‘fat’ body: conspicuous absences, meaningful silences and difficult conversations**

I feel it important to begin by highlighting some of the tensions which arose when I attempted to explore topics around weight and size. Although all of the women I interviewed had elected to participate in a study which very obviously sought to explore topics related to weight and size, it became apparent that drawing attention to

weight and size was something which many of these women actively attempted to avoid in their daily lives. Perhaps unsurprisingly, the desire for hiddenness seemed in large part predicated on the perception of ‘fat’ and overweight as negative and pejorative. In what follows, I touch upon some of the ways these women discussed and demonstrated their attempts to silence, absence and, in a sense, disassociate themselves from their large bodies and the discourses surrounding them.

#### **4.2.1 “Nobody speaks about it, do they?”**

It was apparent from the early stages of the interview process that many of the women I interviewed experienced varying degrees of discomfort when I attempted to raise topics related to body size and weight. At times during the interviews, particularly when I asked *direct* questions related to weight and size, these questions were often met with responses that are difficult to articulate. This sense of disquiet often became manifest in embodied and ‘intangible’ ways: from blushing, to a shifting body position in response to a question, a reluctance to expand on answers or an eager justification. Initially, I conjectured that perhaps some of the questions failed to strike a responsive chord or that there was something about my demeanor which had elicited such responses. However, as the interviews progressed, I also became aware of more overt references, whereby participants described some of the inherent challenges to openly discussing weight and their desire for it to remain absented from conversation. Indeed, Alice provided one of the most salient examples of this in our final interview together:

Alice: (your weight) is kind of an ‘elephant in the room’ type subject. Nobody speaks about it, do they?

SC: When you say weight is like the ‘elephant in the room’, are you referring specifically to conversations that you’ve had with doctors or other medical professionals?

Alice: No, just with everybody. No one would say to you, you know something; you need to go and do something about your weight. I would never dream of saying that to someone! I mean I’ve got friends who are overweight and I’m kind of like do you know what you should come to a slimming class but at the same time I don’t want to say to them you’re overweight and you need to (trails off) because it is a touchy subject and you don’t want to upset people’s feelings.

SC: Did you ever have a doctor or a nurse or anyone address your weight with you?

Alice: No, no never.

SC: Do you think you would have reacted poorly if someone had addressed it with you?

Alice: I think I would have said ‘yeah, I know’ like in that kind of way where I would have made it clear that I didn’t want to talk about it (laughter) and then that would have been it. It’s not something I would like to have spoken about at the time, but now I feel a bit better because I am doing something because I am nowhere near as heavy as I was so.

SC: Why do you think people don’t want to talk about it?

Alice: I don’t know, it’s just a kind of stigma about being overweight and it not being a nice thing. (Interview 3)

In Alice’s account we see that she characterises weight as a kind of ‘absent presence’ in social interactions, as was evident in her description of weight as “the elephant in the room”, a “touchy subject” and a topic which she would “never dream of” addressing, even amongst close friends. Her account alludes to a kind of paradox which is created by the very obvious and *visual* presence of overweight in social interactions and, conversely, because of the stigma it conjures, there is a need to render it *invisible* by avoiding it as a topic of conversation. It has been argued that obesity is distinct from other stigmatised and visible conditions, and comes with a



heavy moral burden, as it entails judgement/disapproval of others (Jutel, 2005).

Warin and Gunson (2013) argue that ‘fatness’ evokes such disapproval because it is typically perceived as “self-inflicted (through overeating) rather than acquired congenitally or through external factors” (Warin and Gunson, 2013: 1689).

What is clear from Alice’s account is that she was intent on trying to avoid such experiences of stigma, and she describes, hypothetically, what she would have done to ‘shut down’ any conversation in which she might be asked to discuss her weight. Moreover, the heavy moral burden associated with overweight was highlighted all the more when she remarked that she was currently feeling a “bit better” about talking about her weight in light of recent weight loss. This was a notable shared feature of many of the women’s accounts, as weight loss was often eagerly spoken about in a manner which positioned it as “laudable” (Monaghan, 2007: 605), praiseworthy and valorous.

Indeed, like Alice, other participants also described attempting to avoid acknowledging and drawing attention to their weight in very subtle, practical and private ways. Most of the women in this study, for example, intimated that it was a customary practice for them not to weigh themselves. A number, including Bernie, openly indicated that this was a deliberate tactic, employed specifically in an attempt to avoid thinking about and engaging with their weight:

Bernie: You know I tend not to weigh myself unless I’m doing a slimming class, ‘cos you know it’s like a reminder that I need to lose weight (laughter) and then I start to feel badly and then you know I’ll start thinking I have to go and do something about it...I just don’t feel ready to put my body through it (a diet), so I’d prefer to keep myself in the dark just at the moment (laughter). (Interview 2)

Bernie's account demonstrates very clearly an avoidance strategy (Degher and Hughes, 1999) which she employed to circumvent being confronted by her weight as, for her, becoming more aware of her weight was an undesirable experience. Indeed, earlier in the same interview Bernie demonstrated this point well when she recalled her irritation at her weight becoming a constant presence at her antenatal appointments:

Bernie: I can remember (laughter) the third time, the third week I think it was about the third or fourth week going (to the clinic), I didn't realise I would get weighed every single week you went! The poor nurse I gave her a mouthful, I wasn't very nice to her. I think I must have had a really bad day in the office or something, being a bit grumpy I don't know, but I was like oh, I have to get weighed again! And she's like yeah, yeah, you get weighed every week and I was like every week! Is that not a bit obsessive? She didn't know what to say to me (laughter). (Interview 1)

Although, she did not indicate at the time why she had found the requirement to be weighed so problematic, one could surmise, in light of her earlier description of 'keeping herself in the dark', that with the constant monitoring, her weight had become an unpleasant reminder which was imbued with moral failings. Other women too described taking steps to avoid being confronted by their (over)weight. Mel, for example, made reference to intentionally avoiding clothes shopping, particularly during times when she knew she had gained weight:

Mel: it bothers me when I go shopping because I do struggle to find clothes and I have to try on loads of clothes and stuff because even though the numbers are the same they are not the same if you know what I mean and so usually I just get upset, not like bawling in the changing rooms or anything like that but I just feel deflated and it's yeah so whenever I need new clothes is basically when I am like awhhhhh (sigh) nah I don't want to do that and so I avoid going. (Interview 2)

In ways similar to the two women described above, Harjeet also described having taken purposeful steps to avoid acknowledging her large body on a personal level, as

well as avoiding more public encounters where, conceivably, her body could have become the focus of attention:

Harjeet: I feel like hiding myself up like that and I'm even wearing such baggy clothes around the house because I feel so self-conscious... 'cos I am deliberately sitting at home alone and not interacting with people. (Interview 2)

Foucault's (1977) description of Panopticism seems especially apt here. Devised by Bentham, the Panopticon was a revolutionary design for a prison, constructed in a way to allow prison guards in a central tower to constantly observe the inmates in their cells. Most importantly, the inmates had no idea when they are being observed, and, under the constant possibility of being watched, they internalised this 'gaze' and began to watch, discipline and alter their own behaviour accordingly. In a similar way Harjeet hints at an internalisation of a gaze, as she described feeling self-conscious and covering herself up even when she was at home, alone. Both the avoidance of the public gaze and the act of covering herself up could be seen as another example of an attempt to deny, absent and perhaps, to use Robert Murphy's (1991) term, to "disassociate from the body". In Murphy's auto-ethnographic account of his experience of a deteriorating spinal condition leading to paraplegia, he described his attempts to distance himself from his body as a "kind of etherialization of identity", perhaps too these women's attempts at avoidance could be considered more specifically as an "etherialization" of a 'fat' and stigmatised identity (1991: 86).

In the next section, I go on to explore how these women talked about and conceptualised their weight and size, where, again, it became apparent that the desire

to maintain absence and create distance from the large body and discourses surrounding it featured prominently.

### **4.3 Conceptualising ‘fatness’**

As discussed in Chapter 3, from the outset I deliberately elected not to use the word ‘obese’ or derivatives thereof, in the title of my study or on any of the participant information sheets, due to the potentially pejorative nature of this word (Saguy and Riley, 2005). This fact notwithstanding, over the course of my interviews with Susan and the other participants, I became drawn to the notable absences of these (and other words) from their self-descriptions. For example, as highlighted in the opening vignette, Susan never used the word ‘obese’ or ‘fat’ in her own self-description. In fact, over the course of the 42 interviews, such terms were only mentioned a handful of times, and, on the few occasions where they were employed, they were uttered in reference to a category which participants related had been assigned *to* them, as opposed to one they elected to use when describing themselves. Similarly, the word ‘fat’ was rarely uttered and, when it was, it was typically employed in a manner which implied negative associations. These findings mirror a growing body of work (see Dutton et al., 2010; Gray et al., 2011; Wadden and Didie, 2003; Volger et al., 2012) all of which have suggested that terms such as obese and fat are typically considered undesirable, particularly amongst large individuals. Indeed, Puhl et al.’s (2013) survey of over a 1,000 people designed to assess the perceptions and preferences associated with 10 common terms to describe body weight, concluded that terms such as ‘morbidly obese’, ‘fat’ and ‘obese’ were “perceived to be the most stigmatizing and blameful” (2013: 616). Warin et al. (2011a) suggest that such

resistance to categorisations is not altogether surprising when one considers “the profound stigma that is associated with bodies that are labeled as deviant and out of bounds” (2011a: 29).

Characteristically, when participants did speak about their weight and bodies, they, at times, elected to use more colloquial expressions such as “wiggly”, “stocky” or “big boned”. More frequently though, they tended to use comparative terms such as ‘bigger’, ‘heavier’ ‘larger’, ‘overweight’ and ‘higher BMI’. Directing one’s attention a little more closely to the words themselves, it could be argued that they can be seen to reflect not only an incorporation of predominant biomedical uses of *relative* measures of weight such as BMI into embodied understandings of weight and size, but also a subtle, but important, comparison to the bodies of others.

There were also more overt and explicit references to the bodies of others which seemed to form an important backdrop upon which participants drew to make sense of their own weight and size. A pertinent example of this is provided in the account below, the thread of which began when I asked Tara to talk about her history of weight management:

Tara: I suppose I’ve always been larger well (laughter) I like to think of it as a case of I’m a bit taller than most people, so I kind of take that into consideration, even though apparently, according to the doctor I am morbidly obese!! Do you know I’ve seen bigger women and I kind of think I’m not that bad, I am just a bit wiggly. (Interview 2)

In Tara’s account we see that she very clearly attempts to make a feature of being a “bit taller” and, by doing so, makes a logical case for why she is larger. In her account we also see resonance with the previous discussion, as her use of the word ‘obese’ reflects her doctor’s characterisation of her body and not her own. This was a

designation which she found contentious and one which she ultimately rejected in favour of her own subjective and relationally informed understanding of her size. This was evidenced in her iteration: “Do you know I’ve seen bigger women and I kind of think I’m not that bad, I am just a bit wiggly”. In her utilisation of words such as “wiggly” in her self-description she also draws attention to what Monaghan (2007), in his ethnography of a mixed-sex commercial slimming club in the UK, describes as a significant schism between “medical and everyday definitions of obesity” (2007: 592). In certain ways, this discrepancy was further exacerbated by the manner in which she referenced the “visual extremes” (Monaghan, 2007: 592) represented by the bodies of other larger women and how she used these to rationalise her weight and to repudiate the clinical classification of ‘morbid obesity’. In distancing herself from obesity discourses (and the ‘deviant other’) in this way, arguably she creates space for an alternative discourse, from which her own understanding of weight and size could be positioned (Warin et al., 2011b).

Like Tara, other participants also conceptualised their size in relation to the bodies of others. This included Lisa who, in the account below, characterised her size by attempting to actively differentiate herself from what she saw as the deviant ‘other’:

Lisa: I don’t feel judged for being fat, that’s never been a problem. I’ve got plenty of friends, I’ve got a lovely husband, I’ve got a normal job, I’m not like I, I don’t struggle to do anything. I don’t really see myself in the same category as, well you know these people that like you hear eat fifteen pot noodles and you think really? Fifteen pot noodles!! You think that’s a good plan? And an entire multipack of crisps! Really? (Interview 1)

In Lisa’s description of her size, she can be seen to both reproduce and simultaneously resist dominant obesity discourses. She did this by drawing on (yet rejecting for herself) what (Throsby, 2012: 9) calls the “familiar characterization of

fatness [as] uncontained appetites” as well as her indirect characterisation of *other* ‘fatter’ people, as bereft of friends, a romantic partner, unable to maintain ‘normal’ employment and as being physically incapacitated. Although she comfortably and openly described her herself as “bigger” at various points throughout our interviews, it is clear in the above account that she was attempting to make an important distinction about how ‘fat’ she felt she was in comparison to other supposedly larger individuals. Crucially here, she is also attempting to make an important moral distinction between her and other ‘fatter’ individuals, who she posits as being out of control. Degher and Hughes (1999) make a similar point in their work, and suggest that amongst their participants, who were all members of a weight loss club, that such a strategy was often employed in an “attempt to escape the full weight of the negative attributes” and to “neutralize the pejorative fat status” (1999: 17). Both Tara’s and Lisa’s accounts also resonate with Samantha Murray’s (2008) autoethnography of her experiences of being ‘fat’ and her suggestion that the bodies of others form an important, if not crucial, ‘perceptual backdrop’. Such a backdrop, she contends, not only informs our understandings of body size but also allows one to imagine “a hierarchy of ‘fatness’ in which one is *well* placed” (my emphasis) and that one’s “sense of self” is in essence “maintained” by measuring oneself “favourably against other ‘fat’ girls” (Murray, 2008: 139).

Other women in my study similarly appeared to be placing themselves in a ‘hierarchy of fatness’ but also indicated that positioning themselves in such a manner, performed an important function, in that it seemed to restore an underlying and erstwhile sense of self-worth. This was poignantly illustrated in Mel’s description of her experience of attending the specialist antenatal metabolic clinic:

Mel: I wasn't even so self-conscious 'cos sometimes I would go to the clinic and there would be women that were bigger than me and so then I was like I am not the biggest one so then, it sounds bad, but I did feel a bit better in myself. (Interview 1)

In a similar manner to Donna, Mel also described being weighed at each visit to the antenatal clinic and suggested that she had not felt “judged” and had felt “much better” about herself, in part, because the duty nurse responsible for weighing her “wasn't a skinny mini herself”. Like Tara and Lisa's earlier accounts, both Mel and Donna can be seen to draw on a highly subjective and relational understanding of body size and weight. Moreover, Mel and Donna's accounts can be seen to highlight what Warin and Gunson (2013) describe as “the unspoken vulnerabilities” and the potential “imbalance of power that accompanies bodies” (2013: 1692). Had Mel, for example, failed to encounter larger women at the clinic, or if Donna had been weighed by a nurse who she had perceived as being significantly smaller, then, conceivably, their experiences might therefore have been markedly different. In this regard, both of these accounts touch upon the notion that the shame and stigma around overweight can be silently and implicitly communicated *through* the descriptions or perceptions of the bodies of others. Also, they hint at a rather fluid conceptualisation of body weight and size, one which conceivably changes in different contexts and in the company of other bodies. Longhurst (2005) also makes similar point:

Fatness and thinness are not binary terms but exist on a continuous spectrum. Even within a day people can feel different sizes and shapes depending on an array of factors such as clothing, feeling of well-being, the activity being undertaken, and interactions with people... (u)nderstanding fat in this way does not mean ignoring the materiality or fleshiness of bodies but recognizing that bodies are always situated in multiple psychoanalytic, discursive and material spaces. (2005: 249–250)



Like many of the participants' accounts presented earlier, Longhurst's assertion draws attention to the malleability of the (large) body and how 'fat' can be understood and experienced in different ways, depending on the social and physical context. This also speaks more broadly to the multiplicity of the body which will form a central feature of the accounts of health presented in Chapter 5.

What these accounts also communicate as a whole is that individual conceptualisations of fatness and body size were complex and far from straightforward. Time and time again these accounts appeared to reflect a nuanced, subtle and constant awareness of the need to "negotiate and resist the discreditation of the fat self" (Throsby, 2007: 1562). This negotiation was evidenced in the women's attempts to abscond their bodies in daily life, in their use of particular terms (over others) to describe their bodies and in the specific manner in which these women referenced the bodies of others. In large part these would appear to be strategies which were employed in an attempt to legitimate their own body size and restore and/or maintain some sense of moral worth. The importance of relatedness of the bodies of others will be further highlighted in the next section, where I discuss how participants drew (in part) upon the perceptions and description of the bodies of other family members, in their attempts to account for their body size.

#### **4.4 The genesis of body size and weight**

In the following, I address the principal ways in which the women in this study described and understood the origins of their size. In this analysis I draw primarily on the responses to the parts of the interviews in which I asked participants to discuss the geneses of their size. Participants overwhelmingly drew upon lay notions of

inheritance and indicated that heredity was the most significant factor influencing their size and weight. Some also described particular life events or “critical moments” (see Holland and Thomson, 2009; Thomson et al., 2002), which they positioned as being significant in influencing their weight. Moreover, for many of the women, a consideration of the origins of their size appeared to be a subject on which they had reflected previously, perhaps highlighting its saliency to their biographies and the need to have a coherent narrative to hand, from which they could justify and legitimise their size.

#### **4.4.1 Inheritance**

Like Susan in the opening vignette, the majority of women in this study accounted for and explained their size by drawing on lay notions of inheritance. They did this by suggesting that their body size could, in large part, be accounted for by the fact that they ‘took after’ certain close family members. Indeed, in the excerpt below, Tara offers a very typical rationalisation of her size by implicating a shared heritage of ‘fatness’ with other family members. Although she did not explicitly use terms like ‘genes’ in her description, nevertheless, by referencing the bodies of other family members, she implies “a process of biological inheritance” (Richards et al., 1996: 249):

Tara: It is just how I was made I suppose. My dad is a stick (laughter) and my Mum, she used to be quite thin and she’s actually really quite wee, she is short, she used to be thin and then she stopped smoking. One of my grandmothers is wee and the other grandmother she is quite tall but she was quite big as well you know, so I think it’s kind of on my dad’s side of the family that I’ve taken the bigger shape you know. I am more kind of a pear shape, like my granny. (Interview 2)

Tara's comment mirrors the findings of other studies, for example Backett-Milburn et al. (2006) who explored young teenagers' perceptions of their own and others' bodies and found that body size and shape were often "contextualised within descriptions of other members of their nuclear family" (2006: 631). Also, Throsby (2007) in a study which looked at the origins of obesity amongst weight loss surgery patients, reported that all of her respondents drew on lay notions of inherence, by making references to the "family fat gene" and a "familial and kinship networks of similarity and difference in body size," thereby indicating that their bodies were "innately fat-prone" (2007: 1564).

By drawing on the notion of inheritance to explain body size, Tara, like others, can also be seen to resist moral responsibility for fatness and place accountability for her weight, at least in part, as being due to factors beyond her control. Although body size was typically accounted for by making links to the bodies of other family members, as Tara's account demonstrates, this was typically done in a manner which suggested a shared hereditary specifically with other *female* family members.

Similarly, Warin et al. (2011a) in a qualitative study which looked at large mothers' experiences of their bodies, indicated that her participants often spoke of a shared heritage with their mothers' and grandmothers' bodies despite very clearly (albeit, from the perspective of the interviewer) sharing a similar body shape with close male family members.

What Tara's account also communicates, particularly when she made reference to her mother who she described as being "quite thin" previously, but who "ballooned" once she stopped smoking, is a latent propensity to being overweight, which, in this

particular case, was cloaked and concealed by her mother's smoking. Once her mother stopped smoking, her biological destiny was, in essence, revealed. Other women similarly described and accounted for their body size by drawing on a shared heritage of 'fatness' with their mothers, even at times when their mothers were described as having had significantly different body shapes:

Alison: I take after my mum even though to look at her she's quite slim but she's always dieting, like I remember growing up she was always on the grapefruit diet. (Interview 1)

Emily: I think it's related to I mean my mum struggles, my mum is a constant dieter, so is my sister, although they are not as big as me they are always the same, you know oh we've got that wedding in a few months so we need to go on a diet. Anyway I think if it is in your metabolism anyway, if you've been big already you're not going to miraculously get thin so. (Interview 2)

Like Tara's earlier assertion that smoking had masked her mother's true size, both Alison and Emily suggested that dieting had concealed their respective mothers' true size. In doing so, they could still account for their own size by drawing on the notions of inheritance, despite other close family members having slim bodies. By tethering the ancestries of 'fatness' specifically to the bodies of other female family members, arguably mothers are subtly cast as the principal 'genetic perpetrators' of fatness – a fact which could conceivably add to the already existing onus and responsibility mothers bear for the health of their children (Bell et al., 2009).

Moreover, in Emily's entreating of the notion of "metabolism", she is, I would argue, evoking a kind of genetic destiny when accounting for size which also points to a certain inalterability and permanence to her weight. Other participants also articulated a similar understanding of their body size and weight:

Donna: I know there are certain things I could be doing to manage my weight a bit better but that's only going to do so much, I'm a realist like I know I am never ever going to be really light, that's just the way I think my body is and I'm just never going to be that light and that's a fact. (Interview 3)

Despite the fact that Donna and the others positioned their size and weight as predestined and “inborn” (Brodwin, 2002) and alluded to a certain inalterability to their body size, such assertions were not employed as justifications for releasing oneself from the “responsibility of weight management” (Throsby 2007: 1565). In fact, as I will go on to discuss later in this chapter and again more extensively in Chapter 6, most of the women in this study described lengthy histories of repeated cycles of weight loss and weight gain.

#### **4.4.1.1 Bad habits ‘run’ in the family**

Participants also drew on lay notions of hereditary to describe the transmission of certain body shapes and size characteristics, but they also identified certain health-related behaviours as being ‘passed down’ from certain family members. Accounts of a shared heritage of “behaviors” typically arose when these women (particularly first-time mothers) spoke about their future aspirations for their children’s health. Caroline, for example, spotlighted particular behaviours that she did not want her son replicating and, in doing so, implicated a notion of inheritance and a legacy of ‘bad’ habits which had the potential to be passed on from one generation to the next:

Caroline: Because Derick and I are overweight I don’t want Jack (son) to be overweight, ‘cos I have been over weight all my life and it’s the stigma that goes with it, so I’m not giving him any of that stuff (pre-prepared/processed foods). I don’t want him to get into the same sort of pattern that we did where we were stuffing our faces with crap. (Interview 3)

Although Caroline can be seen to make links to both her and her partner's overweight bodies, it is not in the sense that her son may inherit certain genetic predispositions towards overweight, as much as it is a desire for her son to avoid a "pattern" of behaviours, which she identified as being significant in both her and her partner becoming overweight. Emslie et al. (2003) in a study which explored lay understandings of the mechanisms of inheritance, reported similar findings and suggested that their participants identified "behaviours" as well as "genes" as being inherited. Moreover, implicit in Caroline's account is the notion that 'upbringing' becomes articulated in what Davison et al. (1989) have termed, the 'idiom of heredity'. By this I mean, some of my participants referenced their upbringing as influencing "some of the same (or similar) areas of life" which are more typically "deemed to be in the providence of genetic inheritance" (Davison et al., 1989: 337). This included making reference to habits such as "tastes for foods and drinks" and "attitudes to exercise" (Davison et al., 1989: 337), as being inherited.

Other participants also drew up the notion of 'upbringing' to highlight a legacy of 'unhealthy' behaviours, or a certain carelessness or neglect in fostering 'healthful' behaviours which could be transferred between generations. This included Emily who, in the account below, strongly suggested that aspects of her own upbringing had played a major role in determining her current size:

Emily: I want her (daughter) to grow and be as active as possible and maybe not make the same mistakes as I've made...I think when I was growing up I was healthy and I wasn't overweight and I was quite active, it was more as a teenager and things that's when I started to put on weight and stuff like that. My mum and dad weren't particularly like oh! you must go to the gym or go swimming and do this kind of thing so you know they didn't kind influence us in that way. But I think having been slim myself and then having been overweight myself that I'll have a good attitude to be able to tell her well you

don't really want to make the mistakes I made...I think as long as she's a child we'll keep her as healthy as possible and then when she's an adult she's old enough to make her own decisions hopefully we will have given her a good upbringing. (Interview 3)

Inherent in her iteration “when she's old enough to make her own decisions hopefully we will have given her a good upbringing” is the notion that ‘fatness’, was in some ways attributed to a poor parenting. This was a legacy which, for Emily, had extended well into adulthood. Emily's account is also interesting in that she positions her own embodied experience “as having been slim” and subsequently “overweight”, as a useful resource from which her daughter can draw. There is also something striking in her description of her own body as a ‘failed body project’ (Murray, 2005: 155) of sorts and her positioning of her daughter's as a fresh beginning and a chance to right the wrongs of the previous generation.

What is also interesting in Emily's account is that she appears to be exercising her agency in an attempt to influence the decision making for her daughter. However, this was an agency which she seemed unable to employ to change her own health-related behaviours. In this way, her account offers notably different versions of responsibility for weight and size, as she can be seen to take very little accountability for her own weight (by attributing her size in large part to her upbringing), but, conversely, she can be seen to position herself as highly culpable in determining her daughter's weight. This is perhaps not altogether surprising when we consider the powerful and tenacious discourses which are attached to notions of ‘good mothering’ and maternal responsibility for childhood obesity, in which mothers, “in particular are held responsible for the future (fat free) health of their offspring” (McNaughton, 2011: 179). I will revisit this topic again in Chapter 7, where I explore participants'

descriptions of their motivations for weight management and health behaviour change in postpartum.

A number of participants also drew on the notion of inheritance in a way which suggested that an approach to mothering, grounded in self-sacrifice to the diminution of one's own health, had been passed down to them from their own mothers. Both Harjeet and Mel can be seen to demonstrate this point well:

Mel: My mum was big when I was growing up and I remember thinking that I don't ever want to be like that, I am never going to be like that and now I'm not that much lighter than my mum was and she was the same like she was quite athletic and then it was just when she had kids and that became her focus and I see myself in her now just with that lifestyle and stuff so I don't know if it just, I can't blame my mum like I am old enough to make my own decisions but as I say she did everything for us and stuff and didn't take care of herself while she was doing it and that's the way I am myself now with the kids. (Interview 2)

Harjeet: I guess that I don't think of me as a person I think of me as a last person you know I think it doesn't matter about me I can make do, I just need to get everyone else all sorted. I guess I inherited that from my mum as well. She always had that attitude and then my mum says, you used to laugh at me and now you're doing it yourself (laughter) and my mum always says you are going to be the one like me your hands are always going you are going to get carpels from all the work you do, taking care of everybody else, yeah. (Interview 3)

In Mel's account in particular we see that she both accepts and repudiates discourses of individual responsibility for her weight. On the one hand, she suggests that she cannot blame her mother for her decisions, but she then repudiates this by indicating that the 'duty' to mother had in some sense taken dominance over any personal aspirations to health behaviour change. Harjeet's account also puts forward the notion of 'good' mothering as one who self-sacrifices, this is evidenced in her description of herself as the "last person", dismissing her own needs and only considering herself after the needs of other family members have been met. This is a



notion which resonates with the broader literature, and one which was very common across the interviews; that is, that the notion that the ‘good’ and responsible mother is one who puts the needs of her children before her own Lupton (2011: 649).

In this section I have demonstrated how participants employed notions of inheritance to suggest a genetic susceptibility to overweight, when discussing the genesis of their body size and weight. Their accounts also attested to different dimensions of inheritance, as they drew on more traditional ideas about genetic inheritance by referencing the bodies of other family members, but accounts also indicated that certain attitudes related to health could be passed down through families. In the next section, I discuss how certain life events were also implicated as being significant in influencing current weight and size.

#### **4.5 Critical moments**

In addition to accounting for size by making strong links to the bodies and inherited behaviours of other family members, participants also attempted to explain and account for their size by describing certain crucial life events or “critical moments” (see Holland and Thomson, 2009; Thomson et al., 2002). These were typically identified by participants as being important life events that were significant in influencing their weight and tipping them in the direction of what they saw as their genetic destiny to be large. Thomson et al. (2002) first coined the term ‘critical moments’ in an attempt to come up with an operational definition of Giddens (1991) theoretical concept of ‘fateful moments’. According to Giddens (1991), “fateful moments” are times “when individuals are called on to take decisions that are particularly consequential” (1991: 112). Thomson et al. (2002) make a key

distinction between critical moments and fateful moments and suggest that the former arise from narratives and should be considered a “rhetorical device”, employed by a respondent to indicate a “pivot or ‘complication’ on which a narrative structure turns” (2002: 339). Subsequently, these become events which respondents identify as having “important consequences for their lives and identities” (Thomson et al., 2002: 339).

In this study participants gave examples of critical moments which included, but were not limited to: previous injuries, past pregnancies and changes in work practices. Critical moments were consistently framed by participants as disruptive life events, which had reacted powerfully with their ability to enact control over, and successfully manage their weight, and which seemed to be employed in ways which served to moderate notions of individual responsibility for weight and size.

For a number of participants illness and injury were identified as important precipitating events to significant, often long-term weight gain. A pertinent example is provided by Mel, who was one of the few women in the study who recounted a notable history of past involvement in sports and who discussed the onset of her weight gain as follows:

Mel: I used to be a sprinter yeah sprinting and playing rugby and things and then I got injured and really messed up my knee and once I stopped doing that I still kept eating like I was still an athlete but I wasn't burning the calories and so I gained loads of weight (laughter) and I've never really been able to return to that level of exercise you know, like I've tried swimming but it's just not the same thing. (Interview 2)

Although Mel's identifies a past knee injury as a critical moment which was significant in her weight gain, it is very clear that it was not necessarily the injury

itself but the fact that she continued to eat like she was an athlete, that was the most significant factor in her weight gain.

For several participants, changes to work routines were positioned as taking a significant toll on their on their ability to manage their weight. This included Alice, who described the impact of her decision to start shift work on her eating habits, which then resulted in significant weight gain:

Alice: I must say, that's when I did put on a lot of weight when I started working shifts night shifts because you would sit and you would be like oh I'll have some crisps or I'll have some chocolate, I just had a really hard time getting used to the schedule and you're awake when you should be asleep and eating you dinner at breakfast time, I just felt all over the place, you know with it just changing constantly and then I just got into the habit of eating convenience foods, I'd grab a chippy if I was coming home at night or you know I'd just eat whatever was in the fridge when I got home. (Interview 1)

As Alice's account highlights, changes to working lives were typically characterised by a loss of control and routine and which were highly disruptive to eating. As I will go on to show in Chapter 6, the ability to plan meals and anticipate change were identified as imperatives to successful dieting.

For a number of women in this study, past pregnancies were also identified as a significant precipitating factor in their long-term weight gain. A pertinent example of this was provided by Harjeet, who recounted how pregnancy had been such a significant contributing factor to her current size:

Harjeet: With my two daughters I just felt like eating sweets all the time and I did. The first pregnancy you take it quite literally as eating for two, for me as I say it was a time to stop thinking about my weight you know. At the time you don't think oh god I don't want to put on all this weight, you don't really think about that until afterwards but then your caught up with the baby and you don't have time for yourself and you're basically kind of comfort eating your way through the chaos. It was the same again the second pregnancy I

just sort of ballooned...after my first pregnancy I never really regained control over my weight. (Interview 1)

Harjeet's account is interesting for a number of reasons, firstly her account of significant weight gain during pregnancy coincides with the popular assertion of pregnancy as a time where women can and are often encouraged to "relax usual controls" around eating (Warin et al., 2012: 3). Secondly, as will be unpacked in Chapter 7, her account also touches upon the postpartum period as a significant critical moment in her attempts at weight management.

It was a notable feature of the majority of accounts of critical moments that they remained largely unchanged between interviews. However, for some participants, I identified certain nuances and changes to their accounts of critical moments across their interviews. This included Alison, who began by giving a fairly typical account of a critical moment, which she positioned as having been a past precipitating factor for significant weight gain:

Alison: My weight problem was when I was on Depo Provera. After I had my third child, I was on it up until last year when I stopped it. I put a lot of weight while I was on it. After my third was born, I was eating quite a lot of takeaways and things, just for convenience, and it was then I put the weight on. I just really struggled to get it off. I think it's been the injection that's harboured that weight gain and now that I am off it, I seem to be losing weight easily. (Interview 1)

In Alison's account we can see that she clearly identified her contraceptive "injection" as a significant factor in 'harbouring' past weight gain. Moreover, although Alison acknowledged eating a "lot of takeaways" she positioned this as somewhat inconsequential in comparison to the effect of the injection. The legitimacy of this critical moment was in a sense further reaffirmed by the fact that,

according to her, she had lost weight since coming off the injection. In this way, her narrative appeared to match with her subjective experience.

When I met Alison for our second interview, we returned again to this critical moment. Once again she began by telling me that she had started to gain weight steadily after her third child was born. Similar to the previous interview I asked her if she felt she could identify a reason why she had gained weight, to which she responded:

Alison: I can't really well I keep on saying it was after that Depo Provera injection. I think a lot of women on it were saying they've had lots of problems with their weight. But to be honest since I've come off it, the weight has never really shifted and I've been really trying to be honest. (Interview 2)

This critical moment is interesting on a number of accounts, in her evoking of the words "I keep on saying" we get a sense that perhaps she is questioning her initial assumption and that she now appears to be downplaying the role of the injection, as it no longer seems to offer a logical excuse for her weight gain, in light of recent weight management experiences. I interpret her account as resonating with on Bury's (2001) work on illness narratives. Bury cautions that researchers should resist taking accounts at "face value", arguing that narratives "take many forms, have many uses and serve many purposes". For this reason he contends that narratives might be better understood as 'factions' "rather than either fact or fiction" (Bury, 2001: 281). Similarly, Williams (1984) work on "narrative reconstruction" has salience here too. Using a cross-sectional design he explored the causation accounts of people living with rheumatoid arthritis and suggested that the people he interviewed drew on particular "aspects of their biography in order to realign present and past" (Williams,

1984: 197). Therefore, in light of the work of Bury and Williams, it seems reasonable to assume (with the benefit of multiple interviews in this study) that the disparities identified between Alison's interviews can be accounted for as a need to diminish any 'threat' to her moral character (Blaxter, 1997) but also by her need to make sense of her changing experiences over time. By this I mean, she can no longer make recourse to her contraception to account of weight gain as she now has the experience of gaining weight without the contraception. In this regard, Alison can also be seen to appeal to the lay accounts of other women who reported to having gained weight whilst taking Depo Provera and, in doing so, positions this as a shared problem of weight gain and not an individual one. Moreover, by discussing her weight gain in this way, she positions her weight as being beyond her control and therefore repudiates dominant obesity discourse and individual responsibility for weight gain.

#### **4.6 Commentary**

In this chapter, I have shown how the pejorative positioning of 'fat' and overweight socially and culturally speaking was central to how these women spoke about their bodies, weight and accounted for their size. For example, it would not appear to be any coincidence, that most women, like Susan in the opening vignette, omitted using certain words like 'obese' and 'fat' in their accounts. Moreover, it does not appear to be by chance that they constructed such detailed and nuanced narratives when talking about their body size and weight, which seemed to play an important role in terms of their self-presentation (Goffman, 1959). In later chapters, I will continue to show

how, for these particular women, the stigma associated with overweight, seemed to impact how they talked about their health and certain health-related behaviours.

This chapter has also drawn attention to the ways in which the majority of participants tended to draw on notions of inheritance to explain and rationalise their body size and weight. They also implicated differing notions of inheritance, by draw on lay notions of hereditary to describe the transmission of certain body shapes and size characteristics, but they also identified certain health-related behaviours as being ‘passed down’ from certain family members. In doing so, I have argued that many of these women seemed to be placing individual responsibility for their own weight and size as being at least in part outside their immediate control and yet positioned themselves as highly culpable for their children’s weight management. These differing versions of responsibility for their own weight versus their children’s seemed to be influenced by ‘good’ mothering discourses and is an issue which will be revisited and explored further in Chapter 7. Moreover, how these women talked about and understood the genesis of their size, has important implications for their approaches to weight management and this will be further explored in Chapter 6.

## Chapter 5: Constructing health as a large woman

### 5.1 Introduction

Radley and Billig (1996) begin their paper '*Accounts of health and illness: dilemmas and representations*' by posing the following question: "What are individuals *doing* when talking about their state of health?" (1996: 220, *my emphasis*). To be clear their use of the term 'health' (and mine, for the purposes of this discussion), refers to how people conceptualise their health more generally. This offers a different perspective to health than, say, engagements with health-related behaviours, and, while they are often extrapolated to build a broad picture of health, they do not speak directly to how people conceptualise health *per se*. I have also placed emphasis on the word 'doing' in their question, as it hints to a broader discussion; that is, that the manner in which people speak about their health is in some sense deliberate and performs an important function in terms of self-presentation.

Building upon these ideas, this chapter explores how the women in this study more broadly conceptualised and understood their health as large women. I begin by exploring how my participants talked about and understood the relationship between weight and health and the role it played in their sense of self. Following on from this, I look at how these women utilised the notion of 'absence' in their conceptualisations of health and the role it played in their assessment of their present and future health risk. As part of this discussion, I also draw attention to the contexts in which my participants described their health (and weight) as becoming more salient.



## 5.2 Exploring the relationship between weight and health

When attempting to address the topic of health with my participants I began by asking a version of the question: ‘What does healthy mean to you?’ which I then followed up with a series of prompts, where necessary, aimed at encouraging and eliciting rich and engaged responses. Although I did not follow a strict order, I had resolved to leave questions regarding any possible links between health and weight until later in the discussion, as I was keen to see if the topic would emerge organically in conversation. I felt that this was important because I did not want to inadvertently ‘frame’ my findings nor did I want to engage in any value judgments with any suggestion that the two might be connected. If participants mentioned weight in their conceptualisations of health then I had planned to follow suit and attempt to unpack and explore this topic in a much more in-depth fashion. However, my caution was perhaps unfounded as, across participant accounts, there were unprompted and striking references to weight and its relationship to notions of health. In fact, more often than not my participants seemed to regard health as being synonymous with weight, at least in the sense that, when I asked participants to talk about health, the majority responded by making an immediate reference to their weight. Indeed, in the account below Susan offered a very typical response to a prompt in which I had asked her to describe what healthy meant to her:

Susan: You know I’ve probably been so unhealthy all my life that it’s probably (laughter) hard to say if I’ve ever been healthy you know what I mean (laughter), ‘cos I’ve always been overweight. (Interview 2)

That Susan and many of the other participants so consistently referenced their weight immediately when asked about their health, I would argue is reflective of their

awareness and internalisation of broader discourses which routinely position ‘fat’ as unhealthy (Evans and Colls, 2009; Guthman and DuPuis, 2006). Furthermore, one could argue that by acknowledging their weight in such a manner that they were attempting to ‘neutralise’ a potentially anxiety-producing subject by raising it as a topic of discussion. Arguably, once the issue had been addressed it was “no longer taboo” and could therefore be more “easily managed” within the context of this particular social interaction (Stuenkel and Wong, 2013: 51).

Although Susan began by making a somewhat tenuous reference to her weight and its relationship to her health, after a short pause and in a more serious tone, she went on to qualify her comment further:

Susan: Actually, probably when I lost that six stone that is when I probably felt the healthiest. But you know it’s quite strange ‘cos when people talk about when you lose the weight and that you just feel so much better and I think ‘cos it’s such a slow gradual thing that you don’t just all of a sudden feel overnight oh my god! or even like when I stopped smoking for six months that you feel so much better for it. I’ve never got to that stage, I don’t know if I expect too much that I should have all of a sudden be like, oh! I feel SOOO healthy now ‘cos I’ve stopped smoking and lost weight. (Interview 2)

While she began by suggesting that she had “probably felt the healthiest” when she had lost a significant amount of weight in the past, her account of the impact that this weight loss bore on her health seemed far from straight forward. This sense of ambiguity was highlighted in her iteration, “when people talk about when you lose the weight and that you just feel so much better...I’ve never got to that stage”. On the one hand, it could be argued that, by saying this, she positions her own embodied experience of significant weight loss as pushing back against a broader cultural script which routinely and unequivocally equates slenderness with healthiness and weight loss with tangible and significant improvements in health. On the other hand, her

account could just as easily be interpreted as ‘buying into’ this script by indicating that perhaps she had failed to lose enough weight to truly be healthy.

### **5.2.1 “You don’t have to be stick thin to be healthy”**

Like Susan, other women responded to prompts aimed at exploring their conceptualisations of health by immediately referencing their weight, but most tended to offer a much more explicit challenge to the link between overweight and ‘poor’ health than Susan had done earlier. One of the women who conceptualised the relationship between her weight and health in this way was Donna:

Donna: I know there is this whole thing about you can’t be healthy and overweight but personally I do think you can be healthy and overweight, well not be really overweight but you know you don’t have to be stick thin to be healthy because some people who are really thin and are really unhealthy and I think too I’ve seen plenty of bigger women who are very healthy go the gym, do jogging and things like that so I think to a certain extent yeah, but there are people who are big, I’m not saying really big but are slightly overweight who are healthy. (Interview 2)

Donna clearly rejects the inference that overweight is necessarily and inevitably linked to poor health. She also, in essence, defends her position by making reference to other ‘bigger’ women who are active and going to the gym and, in so doing, draws on popular health promotion discourses to construct health as linked to an active lifestyle and subtly moves the focus away from size (Campos, 2004; Cogan and Ernsberger, 1999). This resonates with the earlier discussion in Chapter 4, where a number of the women in this study described understanding and rationalising their size in relation to the bodies of others, although, in this case, she references what other bodies can ‘do’ rather than focusing on appearance. In Donna’s account we also see resonance with the work of Davison et al. (1991) who suggest that people

often make assessments about their own health risk, based on their observations of others and who coined the term ‘lay epidemiology’ to explain this phenomena. For example, Donna can be seen to make conclusions about her own health, at least in part, by drawing on her observations of other overweight women who she positions as successfully leading healthy, active lives. Arguably, by doing so, she pushes back against the public health discourse that decries the possibility of health for large individuals and the assuredness of health for those who are ‘thin’.

Like Donna, others similarly refuted the salience of discourses that equate health with weight, one of the women who described her health in such a manner being Tara:

Tara: I suppose healthy means em, to me it would mean, just I don’t know really its em, I’ve never really been asked anything like that. I suppose it would probably be more a mental thing for me because, a lot of people associate healthy with having a good figure and that is something I’ve never ever been interested in as you can probably tell (laughter)...to me health would probably be more a state of mind rather than how I look, how people perceive me, rather than worrying about do I look thin? Will I fit into this pair of trousers? To me that obsessive, like I’ve never, ever caught on to that type of fad do you know where I have to wear the latest trend and oh! I have to fit into those skinny jeans that make me look like I’m going to fall apart (laughter) or the buttons are going to ping (laughter), you know, that’s just not me, yeah that’s not me at all. (Interview 2)

Like the other women described above, Tara began by immediately referencing her weight but also went on to state that she had never associated health “with having a good figure”, and jokingly indicated that her large body was in a sense testament to that assertion. Moreover, in her account she can be seen to situate thinness as a largely aesthetic ideal (not necessarily a healthy one), fuelled by fads, trends and “obsessive” desires and superficial concerns about looking thin. She also implies an embodied frailty which she describes as accompanying thinness. This is apparent in

her iteration “I have to fit into skinny jeans which make me look like I’m going to fall apart”. In doing so, she positions her large body as more healthy and resilient in comparison to the frailties of thinness.

It is also worthy of note that Tara was also one of the few participants in this study to have allied her health so explicitly to her mental health, as the majority of participants discussed their own health in much more physical and corporeal terms. Moreover, it is plausible that she described her health specifically with reference to her mental health in an attempt to position herself as being outside the hegemonic discourses surrounding weight and health, discourses which allow little room for conceptualisations of good health for bodies over a certain size/BMI (Bacon and Aphramor, 2011). In doing so, it could be argued that she was attempting to create an opportunity for alternative narratives which allow her to present and sustain a better and more moral version of herself.

Although these accounts were far from straight forward, as a whole they appeared coherent in that they rejected (at least in part) the popular discourses which present a “simplistic correlation” between weight and health and which position the large women as “always-already unhealthy” (Tischner, 2013: 77).

### **5.3 Using absence to rationalise health**

While the previous accounts both acknowledged and refuted the links between weight and health (often simultaneously), when participants did go on to describe their health in more detail, they tended to conceptualise health by drawing on notions of ‘absence’. For example, a number of women drew on biomedical notions of health and the absence of medical interventions when conceptualising their own health:

Liz: You know I think for me health is, well, more kind of medical stuff as well I never go to the doctors 'cos I am never ill. The last time I was at the doctors apart from the pregnancy it was a year ago and I had a really bad chest infection but apart from that I never really feel ill, like I would say I was quite healthy. (Interview 2)

Liz's comment highlights the notion expressed by a number of participants that not having to go to the doctor connoted 'good' health. Her conceptualisations of health also broadly parallel the existing literature which suggests that most people, whether they are 'fat' or not, conceive and present good health as the absence of disease/illness (see for example Blaxter, 1990). I would also argue that this apparently simple assertion also speaks to the complex moral dimensions of health as a large woman, as time and time again participants seemed eager to position themselves as being in 'good' health and, therefore, could be seen to resist the "culturally prominent subject position of the unhealthy fat person" (Tischner and Malson, 2012: 55).

Others too appeared keen to rationalise their good health by drawing on notions of absence, but in slightly different ways from those described above:

Jane: I would say that I am very healthy considering the weight that I am. Anytime I had blood tests or any screenings or anything like that I have regularly been told that I am in ridiculously good health. I know I should probably be about four stone lighter but that's just life and to be honest I'm not sure my life would be drastically different, I would buy smaller clothes and I think that's probably all and for me that's not an incentive (laughter) I think if I was like struggling with everyday life or if I was having like sore knees or like diabetes or if I was finding it hard to breathe or if I was finding it hard to walk for long periods of time that would like encourage me but I don't have any of those problems so. (Interview 2)

Tara: I'm happy with how I am and I'm not really suffering from really that many health problems, you know? I do have asthma but it's not something that is bothering me. If it was bothering me and you know started to get in the way of me doing things then I would kind of say to myself, right! You need

to lose a bit of weight. The moment that asthma starts bothering me that will be it! (Interview 2)

Despite acknowledging that she “should probably be about four stone lighter”, Jane, like Liz in an earlier account drew upon and utilised the medical model of health to justify her health by suggesting that anytime she has had “blood tests or any screenings” that she had been informed that she has been in “ridiculously good health”. Furthermore, both Tara and Jane conceptualised health as an absence of immediate health problems and physical encumbrance to ‘do’ things, but also seemed to use this as a rationalisation for why their weight was somewhat inconsequential to their present state of health. In this way, their accounts show resonance with Van Hooft’s (2006) description of health as “implicit “ in that it is “not experienced as a state in our being, but as the absence of hindrance in our activities” (2006: 115).

Tara and Jane also appear to conceptualise acceptable health as “a range of less than perfect health” within which it is possible to be considered healthy (Twaddle, 1974: 31). The notion of ‘less than perfect health’, as both of their accounts clearly demonstrate, is not a health state in which one is ‘striving’ towards a healthy ideal, but a health state which is ‘good enough’ as long as they can comfortably accomplish the tasks of daily living. This is keenly apparent in Tara’s iteration that unless her asthma started to affect her, only then would she be prompted to address her weight. Jane was more explicit and whilst acknowledging that she was about four stone overweight, she stated that she would be unlikely to address her weight unless she developed health problems. In the absence of immediate and tangible ill health, she expressed doubt that weight loss would noticeably affect her life, “I’m not sure my

life would be drastically different” and concludes that the lure of smaller clothing was therefore “not an incentive” enough for her to lose weight. In this way, we see resonance with Leder’s (1990) concept of the ‘absent body’ and his assertion that health is largely implicit in our lives, typically fading from conscious experience, residing in the recesses of our awareness when we are in good health, and often only ‘seizing our attentions’ at times of dysfunction.

### **5.3.1 “I’ve never really thought too much about the future”**

What is also interesting in the accounts above is that many of the participants seemed to be largely disengaged from notions of future disease risk, at least as far as their own health was concerned. Across the majority of accounts, perceptions of health seemed very much grounded in the present. This was apparent both from the absence of notions of risk in their depictions of health but also evident in more explicit references. A pertinent example of this is provided in the account below. The tread of this discussion began when I spoke to Lisa about her experience of GDM during her recent pregnancy. During this conversation, she indicated that she had a significant family history of diabetes, with her brother, father and grandfather all diagnosed with type 2 diabetes. I then enquired further as to whether she herself had any concerns about developing diabetes in the future and, if her family history of diabetes had ever informed decisions she made presently about what she was eating. She responded by saying:

Lisa: I don’t feel unwell so I think why give myself something extra to do, you know I think in an ideal world we could all pretend we are going to change the way we live but I think realistically there is nothing unless something really horrific happened to me like I had a heart attack or I actually developed diabetes or something like that I don’t think I’m ever going to change the way I live...I think that I control my weight as much as I can be



bothered and enough for it to work to the extent that I want it to while I still enjoy my life em. (Interview 3)

Despite the proximity of this illness (diabetes) she iterated that she was not currently nor did she plan to engage in any health-related behaviours with the specific intention of safeguarding her future health. Furthermore, she added that her lack of concern for her future health was largely contingent on the fact that she did not currently feel unwell: “I don’t feel unwell so why give myself something extra to do”. Here we get the sense that currently any interference caused by overweight as she goes about the tasks of daily living is significantly less intrusive than the potential imposition which would arise from by dieting and managing her weight.

Other participants also described an awareness of their future health but again this seemed a distant and detached prospect in the absence of illness and/or physical limitations. Emily, for example, described her recent pregnancy and the birth of her first child as one of the first times that she had really given any consideration to managing her weight for health reasons and for her future health:

Emily: Yeah, I don’t think I’ve ever, I’ve never had a health scare of anything like I think being pregnant was the first time I realised that I had to lose weight for being healthy and being able to have a good delivery and things like that, whereas before I always felt healthy but was doing it like for photos or holidays...to be honest, before I had her I never really thought too much about the future because you don’t do you when you’re feeling alright. You just kind of get on with it like I’ve never thought oh well I have to change because I’ve always like I’ve still been relatively healthy, although I know that I really need to lose weight to be healthier in the long term. (Interview 2)

As we can see, her account draws heavily on the notion of health (and body) as functional and instrumental, evidenced in her assertion that she lost weight so that she could have a “good delivery”. Moreover, her account also speaks to the importance of context to understandings of health, and that her weight and health

became in a sense more salient during her pregnancy than it had been previously in her life. In Emily's account, although she clearly articulates an awareness of public health assertions that frame overweight as detrimental to long-term health, we see that, in the absence of her own embodied experience of illness or struggle, that, ultimately, she did not see the need to "change" her behaviour.

#### **5.4 "Presencing of the body"<sup>23</sup>: Context, weight and health**

As the above discussion has highlighted, accounts of health were emphatically (dis-)embodied and predominately drew upon the notion of absence, which was typically employed by participants as a way to rationalise and make a case for good health, despite their large bodies. Utilised in this manner, the 'absent' body also illuminates what I would describe as the relatively low expectations of health many of these women articulated. Health was largely seen as functional, instrumental and unproblematic, in essence, 'good enough', if the body remained reasonably absent as they went about the tasks of daily life.

In the following, I go onto discuss the flipside of those accounts; that is, accounts which describe the connection between weight and health as a "presencing of the body" (Leder 1990: 82). 'Presencing of the body' within the context of this study refers to the times and contexts in which participants described a growing awareness of their large corporeality in ways which gave them pause to (re)consider their health. For a number of participants, their health and the negative impact their weight

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<sup>23</sup> Leder (1990:82)

was having on their health, became particularly salient when they spoke about engaging in certain physical activities:

Alison: I do feel healthy at the moment but it's a bit of a trick question, like I do feel unfit? Definitely, but I don't feel ill, if you know what I mean. I mean like lately I've noticed that when I am doing exercises I think oh! God this is really hard and it never used to be you know? Like, I've started to feel out of breath really quickly and I think that's the weight...I don't mind the, well I do mind - I hate when I get really hot and sweaty I think you know when you're not exercising and you become hot and sweaty and out of breath and you're not even doing anything! Even just walking around sometimes can be difficult and I suppose running after the kids to tell them off (laughter).  
(Interview 2)

Alice: I think you can feel quite healthy and be overweight until you go to do some physical activity and you struggle, like if you have to run for a bus or something like that or it's happened a couple of times recently at work when the lift's been broken and you've no choice but to haul yourself up the stairs and before you know it you are huffing and puffing and then you realise perhaps I am not as healthy as I think I am and you think to yourself, yeah I need to do something about this extra weight I'm carrying around because it's beginning to affect my health you know. (Interview 3)

Notably Alison began by describing a certain ambiguity around her health status, suggesting that it is a “bit of a trick question” and that, although she was not ill *per se*, she did feel unfit. What is also salient is that both women's accounts highlight the importance of context to understandings of the connection between weight and health, and, more specifically, the ways in which context can play a role in ‘presencing’ the body and health. For example, both women clearly identify particular kinds of physical activities that have caused them to struggle, which subsequently prompted them to think about their health. Alice, for example, described an unexpected run to the bus stop and taking the stairs rather than the lift as a time when her health and the perceived lack thereof, became (at least momentarily) more apparent. Like Alice, Alison also described becoming more aware of her less than perfect health at certain times and in certain contexts. In her

account her fitness seems relative, in that she is basing her present experience of fitness against some past, albeit more fit version of herself, by suggesting that she finds exercise hard and that “it never used to be”.

What is particularly interesting in these women’s accounts is not only their description of the growing awareness of their large bodies during certain kinds of physical activity, but that they also drew attention to certain unpleasant experiences, such as difficulty breathing and sweating, which are perhaps not all that dissimilar to how the body is “presenced” in ill-health. Leder (1990) suggests that when the body is ‘presenced’ in this manner, it causes our “whole being” to be “forcibly reoriented” in an attempt to return the body back to its absent and taken-for-granted state (Leder, 1990: 73). If we accept Leder’s assertion, then it is possible that, for some women, engagements in physical activity and exercise might be better avoided, because in some ways they may have the effect of ‘presencing’ the body, in a similar manner to the experience of illness. Indeed, a number of women described engaging in deliberate strategies to mask the unfit/ ‘fat’ body in their everyday lives by avoiding certain physical activities. Susan, for example indicated that she had previously enjoyed swimming but felt that, because she had gained so much weight, it had now become too physically challenging:

Susan: I used to love swimming before but now I think since I’ve gained all the weight that it just feels too hard, like I’m struggling with every single stroke so I’d rather lose some weight first before going back to it. You know it’s the getting changed beforehand too and getting dressed afterward it’s just that I’m like awwhhhhh (laughter) do you know I feel a bit self-conscious and it’s like, if you could just like magically not have to go through all the rigmarole before and after, do you know. (Interview 2)

Not only does she very clearly demonstrate avoiding swimming because of the unpleasant physical experiences it evokes but it seems that the ‘risk’ of exposing her large body in swimming pool changing area also acts a significant deterrent.

#### **5.4.1 “I’ve got to get back to health”**

Although the aforementioned accounts served to highlight the manner in which participants described a growing awareness of their large bodies and its impact on health, only two women in the study actually described acting on this awareness and deliberately managing their weight, with the specific intention of improving their health.

One of the women who described taking steps to improve her health by losing weight was Salma. In the account below she explained how her decision to lose weight came about:

Salma: I was really, really, really bad I was really overweight. I was 24 stone that was just awhhhh (sigh) I was at my worst at that point in time. It was around the time when my Dad passed away and I started praying. It is part of our Muslim traditions and I used to wash myself five times a day so and I had weight on my tummy and on my legs and I used to wash myself and I used to, do you know, bend down and after a week or so I started to get really bad back pain, like crippling back pain, like I could barely walk, you know, and that’s kind of when it hit me and I was like oh my God the back pain is not coming from anywhere but it is from my own weight ‘cos I am carrying that much weight around my stomach and it was the first time where I felt it was beginning to impact my health and I was kind of like, do you know it is the time for it, so I started to really work on losing weight. (Interview 1)

In her account we can clearly see that she had reached a point where she considered the limitations that her large body posed to her health were no longer acceptable, in light of her experience of “crippling back pain”. This resonates with earlier accounts where a number of participants described feeling it unnecessary to lose weight, until

such time as they experienced illness or were physically encumbered to such an extent that they were unable to carry out the tasks of daily living. Again 'good enough' health would seem to be about having the ability to undertake everyday activities without undue discomfort or difficulty. In Salma's example, this was no longer possible because, as a Muslim, she had to pray and as such this was not an activity which she could necessarily avoid to mask the impact of her weight from herself. Although not immediately apparent from her account, she went on to indicate that although she had successfully lost five stone, over the course of the following year she had regained most of the weight she had lost. What is neglected in her account is why she regained the weight and why her health appeared to have become less salient over time. This is a question perhaps better answered in Harjeet's account below.

Like Salma, the only other woman in the study who described actively and purposely losing weight, explicitly for health reasons, was Harjeet. Her account is particularly interesting because she described being prompted to lose weight by a health problem she experienced during the course of the study. As such the account presented below offers a valuable (and rare) insight as to how her attempts to address her weight, played out over time.

To begin with, Harjeet was one of only of a few women in the study who specially described themselves as having a chronic health problem<sup>24</sup>, the recurring nature of which she linked, at least in part, to her weight and eating habits. Harjeet's health

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<sup>24</sup> Although a number of other women in the study described having chronic health problems, like asthma for example, few tended to present them as such. I can only presume that was because they were not having a notable impact on their ability to undertake the tasks everyday living.

and the urgent desire to improve it seemed particularly salient during our second interview together when she described having very recently experienced a number of oesophageal “attacks”, which she characterised as pain and spasms in her throat, which prompted her desire to address her weight:

Harjeet: I’ve had a couple of attacks recently, they’ve been really strong ones this time and so that’s really prompted me to want to do something about my weight because I feel like that can’t be helping the situation, and so I’ve finally got on the band wagon for losing some weight, about two weeks ago now and I’ve lost four pounds so far. It’s a working effort, it’s not easy, it’s hard, but you know it’s the motivation I’ve got to get back to health!  
(Interview 2)

It seems reasonable to assume that in the presence of ‘dysfunction’ that Harjeet’s previously taken-for-granted body emerged into view and that with that emergence came a desire to address her weight. This is highly salient in her iteration: “I’ve had a couple of attacks so that’s really prompted me”. This is a situation which finds resonance in Carel’s (2007) assertion that the habitual body is “problematized by illness” in large part because during illness we become exposed to the “gap between the biological body and the experience of the lived body, a gap that remains hidden in health” (2007: 99). It is this gap, as previously noted, that Leder (1990) asserts causes our “whole being” to be “forcibly reoriented” in an attempt to return the body back to its absent state, and arguably it was this gap that prompted Harjeet to want to lose weight (1990: 73).

Though the previous extract suggested that Harjeet intended to take steps to lose weight when I returned to revisit her for her final interview, some three months later, that sense of urgency around her need to lose weight to improve her health had

waned considerably. I was particularly keen to explore why her desire to lose weight was now less salient:

SC: So last time I visited you had just started a diet. Can I ask how that is going for you?

Harjeet: Well, my diet is gone out the window. How much had I lost when you were here last?

SC: I think you had lost somewhere in the region of four pounds.

Harjeet: Yeah that's right and I went on to lose a total of half a stone and then my brother had a birthday and it all went back on (laughter) and I never went back on to it.

SC: Aha, so I know you said before that you had been experiencing some attacks which was a big part of the reason why you wanted to lose weight to begin with. Are you still experiencing those or not so much?

Harjeet: No, no I've not had one of those in ages, it was probably around the time you were here before that I had the last one, yeah, I think it was around then that I had the last one...I haven't thought about it but I suppose I don't know when it's (illness) not as in your face you tend not to think about it as much and then life just happens doesn't it and you get distracted and all your great plans for getting healthy and stuff, they just go don't they? (Interview 3)

One could surmise that, in the absence of more recent episodes of ill health, her body and the imperative to "get back to health" had in some respects receded, at least temporarily from consciousness. Perhaps too, the sporadic nature of her 'attacks' permitted a certain amount of complacency with regard to her health, promoting a sort of 'out of sight, out of mind' mentality, which she can be seen to infer in her comment: "When it's not as in your face you tend not to think about it as much".

This account highlights again that notions of absence and presence are highly contextual and that even in the case of illness, there is not a linear and



straightforward shift between notions of absence and presence, as Leder's (1990) descriptions suggest.

## **5.5 Commentary**

Constructions of health for these particular women at this point in their life course were far from straightforward and seemed to reflect a range of divergent views particularly regarding weight and its connection to health. While participants drew on and reproduced popular discourses, which present large women as inherently unhealthy and at 'high risk' for future ill-health, they also challenged those assertions and offered far more nuanced accounts of health beyond a connection to body size and weight. In particular, participant accounts highlighted the role of context in mediating the experience of health and weight. The accounts presented above also reflect a strong moral element as time and time again my participants were keen to position themselves as being in 'good' health or 'good enough' health, as not to necessitate actively engaging in weight management.

Moreover, despite their size, most women suggested that in the absence of ill health and/or physical limitation, that they had only minimal concern for their present and future health. In addition, some women's accounts suggested that they avoided participating in certain physical activities, which seemed to be in an effort to avoid and mask from themselves and others the impact of being 'fat'. When participants did describe becoming more aware of the impact their weight was having on their health, it was often highly contextually based and transient. I will continue to explore the notion of context and the implications for health in Chapter 7, where some women described a growing awareness of their weight and its impact on their health

in the transition to first-time motherhood. Moreover, how these women understood their health has important implications for understanding approaches to and engagements with weight management and health-related behaviours, and these issues which will be explored and discussed in more detail in Chapters 6 and 7.



## **Chapter 6: Accounts of weight management: control and surveillance**

### **6.1 Introduction**

This chapter is the first of two that address the ways in which participants described approaching and engaging with weight management. Here, I explore accounts of weight management prior to the birth of their most recent child, while in Chapter 7 I focus on the accounts of weight management and engagements with health-related behaviors specifically during postpartum. Although this research project was principally focused on postpartum, both historical and more recent pregnancy related approaches to weight management appeared to shape and impact how the women in this study talked about, understood and engaged with health-related behaviours during the first six months following childbirth.

This chapter is split in two sections: in the first, I begin by exploring participants' accounts of their historical approaches to weight management. In particular, I focus on notions of self-control which formed a central feature of their accounts. In the second section, I explore participant experiences of the weight management during their most recent pregnancy, as they attended a specialist antenatal metabolic clinic. Again, as I will show, the notion of control appeared to be a highly salient feature of their accounts, yet distinctive from the preceding descriptions, in that control was most notably linked to ideas about risk to the foetus, responsibility and a heightened sense of surveillance arising from their attendance at the clinic.

## 6.2 “I’ve always been an up or a down type of weight person”

The majority of participants in this study described lengthy histories of repeated attempts to manage/lose weight, with a heavy reliance on commercial diets as the principal approach. Although there was some reference to physical activity as a weight management strategy, it was a far less salient feature of their accounts and tended to be positioned as a secondary activity, engaged with only after a diet had been well established. It is for this reason that this chapter focuses mainly on diet.

When participants discussed their weight management, it was most common for them to describe what is popularly referred to as ‘yo-yo’ dieting. What I mean by this is that they described cycling through periods of gradual weight gain, periods of weight maintenance, which were suffused with periods of moderate to significant weight loss, only to follow what they saw as a predictable return to previous behaviours and eventual weight regain. Indeed, one of the women who described such a cyclical approach to weight management was Harjeet, who in the excerpt below offered a very typical account in this regard:

Harjeet: I’ve always been an up or a down type of weight person, I have never been a steady weight, I’m more like a yo-yo dieter since my teenage years, back then I used to crash diet to stay slim, I think I told you I used to be a model you know, em although you wouldn’t think it now (laughter). You know I’m constantly trying to lose weight, I’ve pretty much tried every diet under the sun (laughter) Atkins, Lighterlife, Slimming World and you know with some of them I’ve lost a good amount of weight, like I lost about four stone in six weeks when I had gall stones but then something happens to put a spanner in the works and you lose control and eventually it all goes back on. (Interview 2)

The majority of participants suggested that these cycles of weight gain and loss, were typically triggered by a precipitating factor which either prompted them to become

more focused on managing their weight, or conversely, to lose control over their weight. At times, these precipitating factors seemed not dissimilar to the ‘critical moments’ which participants identified as playing a meaningful role in influencing the genesis of their size. Indeed, in the case of weight loss, participants typically described being motivated by a desire to lose weight in advance of pregnancy, weddings, other social events and holidays or “decisive moment when women knew they had become too large” (Warin et al., 2011a: 28). For these women decisive moments included a favourite piece of clothing which no longer fitted or in Mel’s case she was prompted to lose weight after being unable to find a seat on the bus which she felt she could comfortably sit in. In Harjeet’s excerpt above we see that she referenced an immediate health problem - gall stones - as a past impetus to lose weight, but for reasons which I have laid out in Chapter 5, health was rarely identified as a strong impetus for weight loss, at least for these particular women at this point in their life course.

Periods of weight loss were characteristically followed by a period of weight regain. Participants again positioned this as being prompted by a precipitating factor. Harjeet, for example referred to such a precipitating factor as a “spanner in the works” (in her account she mentions a family BBQ), which came to represent a period in which she loss of control over her weight. Indeed, it was common for participants to identify reasons for weight (re)gain which often mirrored the very reason the diet was instigated to begin with. For example, in Emily’s account below, she referenced a holiday which she both dieted for, but which had simultaneously appeared to mark the beginning of a period of weight gain:

SC: Can you tell me what kind of things you have done in the past to lose weight?

Emily: Yeah, I've done loads of silly diets like the Atkins diet, no carbs and things like that, but I've also done things like Weight Watchers and Scottish Slimmer's and the Atkins one made me lose a lot of weight very quickly but I think it was a combination of that and going to the gym a lot... I think with every diet I've ever done it's usually for a holiday, like that's when I usually start a healthy regime. Like a few summers ago, we made plans to go to Canada to see family and have a holiday and I was just really focused leading up to it, I joined the gym and I lost a lot of weight but then you find it goes back on quickly. Like when we went on holiday (laughter) you just sorta go off the rails don't you? And then when you get back and you think, oh! I'm going to keep it up (the diet) and you don't, you know you get back into work and you think I'm really too busy but then when something else comes up, like another holiday or something you'll just go and do it all over again which is ridiculous now that I think about it (laughter). (Interview 2)

Emily's account in particular draws upon what Crawford (1984; 2006) terms the meaningful oppositions of 'control' and 'release', which could be used to explicate (at least in part) the recurring and cyclical nature of these women's experiences of weight management. This is an approach to health which, Crawford contends, has been mediated by capitalist ideals, "structured by the mandates of production and consumption", in which the "former emphasizes disciplined, sustained effort and delayed gratification, [and] the latter relies upon desire, play and instant gratification" (2006: 412). This, he suggests, lends itself to "conflict in experience" as individuals attempt to find meaning and negotiate balance with respect to their health, amidst these cultural contradictions (2006: 412).

I argue that the notion of control for Emily was inferred in her description of a "really focused" period preceding the holiday, in which she dieted and engaged in physical activity. In this regard her account hints at motivations for weight management which both draw on wider discourses about getting the 'beach body' ready, but also a motivation to lose weight predicated on the knowledge that the

holiday itself represented an upcoming period of (over)indulgence and release. In some respects this period of control seemed a ‘necessary evil’, in that it (proactively) facilitated or enabled an anticipated period of release. Arguably, in this way, she ensured that she continued to maintain a ‘balanced’ approach to health, however precarious and tentative this balance may have been. In her iteration “you’ll just go and do it all over again which is ridiculous”, we see resonance with Crawford’s earlier assertion that such an approach to health often leads to a “conflict of experience” (2006: 412). For Emily, this appeared to become manifest in the consistent need to redress and restore some semblance of balance, amidst the predictability (and futility) of an approach to health, which for her appeared to be lived between the extremes of discipline and pleasure-seeking, as she oscillated “precariously between bodily discipline and corporeal transgression” (Williams, 1998b: 437).

Moreover, akin to the previous discussion on the genesis of size (Chapter 4), one gets the strong sense from Emily’s account that she is positioning her ‘natural’ and ‘default’ state as being large and that losing weight and being thinner was only ever a temporary state, which she had had to work really hard on to achieve. This is evidenced in her comment about keeping her diet going on her return from holiday, where, once again, one gets a strong sense that staying slim required her to diet. As such, she seems to imply that being ‘fat’ is a ‘default’ state, thus perhaps further corroborating the likelihood of weight regain and the inevitability of a cyclical approach to weight management.



### 6.3 “Getting the balance right”

Unlike Emily who drew on the notions of control and release in the broadest sense, other participants also described approaching ostensibly ‘mundane’ day-to-day decisions about what to eat by applying the logic of control and release, as a trading-off between the two, which they described as a judicious balancing act. This included Liz who described how she attempted to negotiate this balance on a daily basis:

Liz: If I’m hungry I’ll eat whatever just now but later on I’ll think I ate that chocolate bar earlier so I won’t have another one after dinner or I won’t have dessert tonight whereas other days, especially when I have a bad day and then you think oh I can’t be bothered and I’ll just eat rubbish or something.  
(Interview 2).

In her account we get some sense that, although she was actively striving to maintain what she perceived as a ‘healthy’ balance at times, it became a challenging proposition in light of other mitigating factors. In this particular instance she described a “bad day” as significant in tipping the balance, which subsequently resulted in her eating “rubbish”.

Other participants also described the importance of attempting to strike a healthy balance. Although there was a general acknowledgement that having too much release was “unhealthy”, conversely being too controlled was also viewed in the same light:

Bernie: I think it’s getting the balance right, I think it’s unhealthy to be too obsessed with what you’re eating and thinking about it all the time, I mean you can’t deny yourself everything that’s just not possible I think if you starve yourself of everything, then you just seem to seek it out more and crave it more in a sense, so I think it is just getting the balance right.  
(Interview 3)

For a number of participants this trading-off between notions of control and release was used to strike a balance with regard to physical activity as well as eating. Indeed, in the accounts presented below, purposeful physical activity appeared to be positioned as a form of control, which subsequently was rewarded or offset by some kind of release:

Caroline: My best friend and I we got a Living Social voucher off of the internet and it was for something like six boxing exercise classes, not boxing but the boxing exercise that they do. After our first class, which was ridiculously hard she said on the way home, let's go for a burger and chips (laughter) and a cider after as well (laughter) and we kind of just got into the habit of doing that. (Interview 3)

Mel: I was watching, I can't even remember what it was that I was watching but they were saying that kind of people similar to me that would sometimes go to the gym and things and exercise and sometimes like they aren't dedicated to it, that they will actually gain more weight because they think well I've burned all those calories and they end up eating more calories than they've burnt and I was like I may be guilty of that (laughter). (Interview 2)

When I went on to ask Mel to describe in more detail what she meant by her assertion “guilty of that”, she admitted that on occasion in the past when she had attend a fitness class, she had often returned home afterwards and “rewarded” herself for what she described as the “hard work” of exercising, by eating “junk food”. In Mel's account too when she makes reference to a ‘type’ of person, we get the sense that this notion of release was also positioned as kind of disposition, which in ways subtly presented an ever looming threat to notions of self-control.

#### **6.4 “I’m an all or nothing type person”**

Like Mel in the previous account, other participants also described themselves, rather ironically, as posing a threat to notions of self-control. A more explicit example of this was provided by Alison below:

Alison: I just don't trust myself not to give in so I have to pre-empt (temptation by preparing healthy snacks), because I have to have it there and ready because at the time, I may not have time. I've tried to be proactive, I get it all ready and then, even when I went on Friday to my daughter's dance class and normally we take like sweets and things with us just to have a wee snack while we're waiting but this time, well the last two times I've been taking carrot sticks or a bowl of fruit as well, so I'm trying my best to avoid all sorts of situations (laughter). I should be an events planner really (laughter) as I have to plan everything. I said to my mum, don't tell me anything on a whim! You need to tell me well in advance. (Interview 2)

In Alison's account we see that control was positioned as the need for "continued vigilance" (Spitzack, 1987: 362), unwavering discipline and forward planning. It seemed that this was necessary against a characterisation of release which seemed to arise from a conceptualisation of her body (or self) as "ultimately untrustworthy" (Spitzack, 1987: 363). Other participants too mirrored this depiction of control and release as not only characteristic of particular patterns of behaviour, but more generally in positioning themselves as persons who lacked certain qualities, which manifested in an inability to negotiate (with any kind of consistency) the precarious balance between these juxtapositions. This was apparent in the account below, where Susan responded to my request to qualify further what she meant by the term "in the zone", this being an expression she had utilised just moments before, to describe her general attitude to weight management, in particular dieting:

Susan: I need to be in the zone to lose weight, like super focused is what I mean and too it's that I'm an all or nothing type person, I'm either doing it (dieting) or I'm not doing it, there doesn't seem to be an in-between that's what it means, I can't just eat healthy and have the odd wee treat for me it's just so hard to get into that way of thinking. (Interview 1)

Other women too could be seen to position themselves as possessing certain qualities or characteristics which reflected a predisposition to a lack of self-restraint or self-control. For some, such as Harjeet, this seemed to be utilised as a 'justification'

(Scott and Lyman, 1968) for certain morally questionable behaviours, such as overeating or eating ‘unhealthy’ foods:

Harjeet: Like I can never do things by half measures, like if I’m going on a diet I need to be totally in the zone otherwise I find it doesn’t work as I’ve said I can usually keep the weight off for a while but somewhere along the line something happens to put a spanner in the works and I let loose em like I will be going along fine and losing weight and then it will always start off with ‘I’m just going to get a takeaway’ and it just goes from there. It’s almost like being a drug addict. Once you have it you’re gone and when you’re gone, you’re gone. (Interview 2)

In the account above Harjeet highlights the extent of her lack of control by likening herself to a “drug addict”, thereby demonstrating an acute sense of powerlessness to resist the lure of fatty foods. It could be argued that in positioning herself in such a manner, she subtly shifts notions of responsibility for certain ‘poor’ health-related behaviours, as being (at least to some extent) outside of the realm of her control.

Arguably, by describing themselves as possessing particular character traits, which predisposed them to a lack (self-)control, we see resonance with the previous discussion in Chapter 4 and participants accounts of inheritance. Moreover the accounts presented above can also be seen to both enhance and complicate Crawford’s (1984) original concept of control and release where he predominately discussed health as a “distinct goal” and “object of intentional action”, where self-control was positioned as something which one ‘activates’ (1984: 69). Although many of these accounts can be seen to reproduce and utilise notions of control in similar ways, at times too many of these women also seemed to be positioning control (or lack thereof) as a ‘quality’ or disposition rather than an act of self-determination or ‘choice’ to do something.

## **6.5 The ‘gaze’ of the clinic and notions of control during pregnancy**

The section picks up on some of the threads of the previous section by discussing notions of control and release and their relationship to accounts of the experience of pregnancy, as the women attended a specialist antenatal metabolic clinic. In particular I focus on participants’ descriptions of eating and weight management and how these were framed as moral issues, which were inexplicably tied to notions of ‘good’ mothering and discourses of ‘expert’ discipline.

### **6.5.1 Eating to enact ‘good’ mothering in pregnancy**

It has been well documented in the literature that women have a strong moral obligation and duty to ameliorate risk to the foetus during pregnancy (Lupton, 2013; Nash, 2012). Given the ubiquity of risk discourses (Lupton, 1999), particularly around the consumptive practices of the ‘mother-to-be’ (Nash, 2013), it is perhaps not altogether surprising to find that the majority of women in this study described making changes to their diet during pregnancy. These dietary changes were in line with the commonly asserted recommendations which advocate consuming certain foods (and drinks) and abstaining from others. A pertinent example of this is provided in the account below, which is notable in its similarity to the majority of accounts. Here Alice, a first-time mother, described the imperative to make certain changes to her diet once she found out she was pregnant:

Alice: I think I just subconsciously knew I had to eat healthy, like as soon as I found out I was pregnant, the baby came first that was that was my main priority. I just really decided from then on to try to eat a bit more of a balanced diet, to me that came hand in hand with not drinking alcohol and not eating soft cheese. It's just something that if you want to do what's best for baby then that's what you should do. (Interview 1)

In her account, Alice can be seen to allude not only to the ubiquity and pervasiveness of the risk discourse surrounding pregnancy, but her account could be interpreted as reflecting an internalisation and normalisation of these discourses (Foucault, 1979). This is tacitly reflected in her suggestion that she “subconsciously knew” that she had to eat “healthy”, which she indicated was something one “should” do to help ensure the health of the baby. In her account, we also see that the imperative to control aspects of her eating was inexorably tied to ideas of maternal responsibility. It seemed from her account that eating well not only served as a means to an end, but performed an important moral function in that it allowed her to position herself as adhering to notions of ‘good’ mothering, which has been purported in the literature to begin in pregnancy and pre-pregnancy (Markens and Browner, 1997).

Enactments of control around eating for this group of women, however, went far beyond the conventional remit to eat certain foods and abstain from others. Most women described making moderate to significant changes to their diet as well as being *unusually* disciplined and restrained around food. This had significant implications for weight management during pregnancy. For example, whilst no one suggested that they had actively dieted, all but one of the women in this study reported either losing weight during their pregnancy, despite the safety of weight loss being unsubstantiated for large women (Furber et al., 2013), maintaining their pre-pregnancy weight (or returning to it shortly thereafter the birth) or, in the event that they gained weight, indicated that they had gained less weight than anticipated. This latter assertion was based largely on previous experiences of pregnancy weight gain and, for some women, an embodied understanding of how ‘easily’ weight could be gained if left unchecked.

For the women who already had children, most indicated that their experiences of weight management during this pregnancy marked a significant and notable departure from previous pregnancies. Indeed, one of the women who described a change in her approach to weight management in pregnancy was Alison mother of five, who reported losing one and a half stone during her most recent pregnancy:

Alison: Oh I was about a size eight to ten when I had my first one and I got up to about a size 18 with that pregnancy...I took the 'eating for two' to the extreme and to be honest I just kind of approached my other pregnancies in the same way too after that (laughter). (Interview 1)

Her account also begs the obvious question: why was this particular experience of weight management during pregnancy so different to past experiences? In this regard, participants indicated that this uncharacteristic approach to weight management in pregnancy could be attributed in large part to a designation of 'high-risk' pregnancy and subsequent attendance at the specialist antenatal metabolic clinic, which seemed to ensure (to some degree) that this pregnancy became intensely controlled.

Apart from the awareness that pregnancy itself represented a time of heightened risk, many of the women indicated that the impetus to manage their weight had been exacerbated by the knowledge that their weight had presented a further risk to the foetus. Indeed, as I will go on to show, this was a factor which many of the participants suggested engendered a good deal of anxiety and concern. It is noteworthy that, although participants were speaking of their experiences of a 'high risk' pregnancy retrospectively, at times recalling events which had occurred over a year previously, these experiences were retold in detailed and emotive ways.

A pertinent example of this was provided by Mel, mother of three, who in the account below described returning home from her first antenatal appointment at the clinic and discussing her fears with her husband that her weight could be implicated should there be anything “wrong with the baby”:

SC: So you mentioned earlier that you had been classified as high risk for your pregnancy because of your BMI. How did you feel about that? Did it play on your mind at all during the pregnancy?

Mel: I suppose slightly, em well actually if I’m being honest it did yeah, yeah, quite a bit. Well it’s hard not to think about it when you’re going to the clinic every week and being weighed and told that you’re at risk ‘cause obviously I ticked all the boxes (laughter) for all the dangers of overweight. I remember when I first went to the clinic and coming home and really stressing. I remember saying to my husband does this mean that if there’s anything wrong with the baby that it’s my fault because I’m fat? My husband kept saying to me no, the emphasis is that you don’t get fatter and I understood that and I was like, yeah that was a better way to look at it. So I kind of like tried to take that view and for the first time ever during a pregnancy I am not going to put on tonnes and tonnes of weight. Whereas at the start I was quite worried that it was my fault. (Interview 1)

Mel’s account is interesting for a number of reasons and on a fundamental level appears to reflect the additional burden and stress associated with her weight as posing a ‘high risk’ to her baby. In her account we see a strong impetus “not to get any bigger” and to manage her weight during this pregnancy. As she suggested, this was something she had not done in her two previous pregnancies, where she had gained significant amounts of weight, in the region of four to five stones, respectively. The differences in weight management between pregnancies seemed related to the additional ‘surveillance’ she received at the clinic, where she described being frequently weighed. One could surmise that this served (at least in part) as a frequent and tangible reminder of her ‘risky’ status, and the potential danger she herself posed to the baby. In this way it could be argued that her health and risk



status remained 'presenced' (Leder, 1990) and at the forefront of her mind – this was evidenced in her iteration: "it's hard not to think about it when you're attending the clinic every week and being weighed and told that you're at risk".

Later on in this interview she also highlighted a certain futility inherent in her situation and the quandary which her own corporeality and risk status presented to her ability to enact 'good' mothering during pregnancy:

Mel: I mean I know I have a higher BMI and I could understand why they were weighing me, and I knew about the risk to the baby if I gained too much weight and all that, but you're kind of in a catch 22; you're pregnant, you're overweight, you're advised not to diet, not to do too much exercise, so there is nothing you can do to change that right there and then and I really felt like my hands were tied in that sense...it's like whatever damage has been done, has already been done. (Interview 1)

Notions of risk seemed to be further heightened for those women in the study who were diagnosed with GDM. Moreover these women tended to be the ones who reported losing the most significant amount of weight during this pregnancy. This included Lisa who, in the excerpt below, responded to a question about her GDM diagnosis and whether she had worried about how such a designation might affect her baby and her experience of birth:

Lisa: I was worried all the time, I had three growth scans, they said that she was going to be really big at my last scan, they said she was up to the 95<sup>th</sup> percentile but she was seven pounds seven when she was born, so that made me pretty angry, because they had really focused on if you don't control your diabetes your baby will grow too much and that made me think I am going to need a section and I am going to have a horrible birth or that she was going to be unhealthy, that was the most important thing to me and as it turns out they were all wrong. It was stressful 'cos all you want is a healthy baby, 'cos when you are doing tests (blood glucose test) four times a day you can't not be thinking about it and constantly kind of thinking, right, what am I eating and how is that going to affect her, so yeah that was an extra level of stress that really wasn't required. (Interview 1)

It is not, I suggest, a coincidence that those like Lisa who were designated as having GDM, described consistently losing more weight. As Lisa's account highlights, a diagnosis of GDM arguably led to an even more intense period of control and surveillance, more frequent visits to the clinic, additional moral burden in the form of a heightened risk to the baby, and, increased transparency and accountability for eating behaviours, which were tracked via daily blood glucose checks. Indeed, her account, in particular, draws attention to the daily blood glucose checks and how this resulted in her "constantly" thinking about what she was eating and how this might have affected her baby. Again we see a potential resonance here with Foucault's work (1977) and different forms of 'discipline' – from the more obvious discipline provided within the walls of the clinic, but also stretching far beyond its confines, to the propagation of self-surveillance, aided in part, by what Armstrong (1995) calls the "machinery of observation" - in this case daily blood glucose checks (1995: 397). It is also acutely apparent from her account that she found this to be a particularly stressful period, and she can also be seen to harbour a degree of anger at what she saw as an over emphasis (and arguably pathologisation) of her eating during this period. She reaffirmed this again later in the interview and expressed a degree of frustration at the intractability of her designation as 'risky', despite describing herself as having been in good health throughout her pregnancy:

Lisa: Anytime anyone saw me they said you are doing really well, but it was never really taken into consideration like no one ever said you're doing great, your blood sugars are great so you don't need to keep checking those constantly, you can relax a bit and we'll not see you as often (Interview 1).

Moreover, like Mel in the previous account, Lisa also touched upon some of the inter-embodied aspects of enacting good 'health' during pregnancy. Both of their

accounts reflected an imperative to manage one's own (large) body and associated risk, ostensibly for the 'health' of another, as of yet, unborn body. This kind of inter-embodiment experienced in pregnancy is markedly different to the kind of inter-embodied relationship which I will explore later in postpartum, where as a concept it will be used to explicate (in part) the notable shift in health behaviours from pregnancy to postpartum.

Like Lisa, Bernie had a diagnosis of GDM and similarly lost weight during her pregnancy. In many respects she mirrored the earlier accounts by highlighting the inter-embodied imperative to protect the health of the baby, but also subtly pointed to an important temporal aspect of her engagements with certain health-related behaviours in pregnancy versus when the baby was born:

SC: Did you gain much weight during your pregnancy?

Bernie: No, I didn't I lost weight but that was only because I had developed the gestational diabetes because if I hadn't developed that (laughter) I would have gained four stone easily (laughter).

SC: Were you being pretty meticulous about what you were eating? Like did you make a lot of changes to your diet?

Bernie: yeah, I became a bit obsessive I was constantly worried about her (the baby) and what I was eating...if I hadn't developed the diabetes I would have just carried on how I was and more (laughter) and knowing as well that what you're doing is for the health of the baby, kind of kept me going, because when I think of all the parties and that I refused cake, that isn't me (laughter) I'm wanting the corner bit with like the double icing (laughter).

SC: Right and did you find that very challenging?

Bernie: If I'm truthful yes it was, but also on the other side of it, my fear was always what is going to happen once you've had the baby, you know, when I am suddenly not going to have to say no anymore. (Interview 1)

However, in this instance I would like to draw attention to her comment regarding the temporal nature of her eating behaviours and that once she had given birth, her fear was that she was no longer going to have to be as controlled around her eating. In doing so, she can also be seen to allude to the temporary nature of her shift in health behaviours and her fear of gaining weight when she was no longer pregnant. This has resonance with the previous discussion on health (see Chapter 5), where health was often only salient in particular contexts and at certain times. We also see resonance with earlier accounts of historical weight management and repeated cycles of control and release, as she raises the question, tangentially at least, about the implications for her weight management after pregnancy when she “not going to have to say no anymore”.

## **6.6 Commentary**

In this chapter I have addressed a range of issues and highlighted some of the notable aspects in my participants’ accounts of weight management, both historically and during their most recent pregnancy as they attended a specialist antenatal metabolic clinic. Most notably I have drawn on Crawford’s (1984; 2006) assertion that health behaviours in Western culture have a tendency to reflect broader contradictory discourses about self-control on one hand, and excessiveness and consumption on the other, to explain (in part) my participant’s cyclical approach to weight management. Participants also suggested that attempts to engage in successful weight management were further complicated by the fact that they lacked particular character traits which engendered one to self-control.

Notions of control were further complicated in pregnancy where participants described enacting a notable (and in many cases an unusual) degree of self-control. My analysis revealed that eating and weight management were inexplicably tied to notions of risk, ‘good’ mothering, discourses of ‘expert’ discipline and surveillance, which appeared to conspire to ‘help’ them to enact strict self-control during this period. As I have shown, this provided a context which had unique and significant implications for weight management during pregnancy.

In the final findings chapter (Chapter 7) I will show how upon entering postpartum, amidst changing contexts and unique relational considerations, that weight management and ability to enact self-control were again problematised. In particular, the notion of inter-embodiment will be taken forward and developed further in Chapter 7, where I attempt to show the salience of the concept to understanding engagements with health-related behaviours in postpartum.

## **Chapter 7: Understanding health-related behaviours in postpartum**

### **7.1 Introduction**

This chapter will focus on the ways in which the women in this study spoke about their engagements with health-related behaviours (specifically diet and physical activity) in postpartum. I begin by exploring what participants had to say about their intentions and motivations to engage in health behaviour change. I then move on to explore how these intentions played out in reality and over time. I pay particular attention to the inter-embodied aspects of their accounts and explore how such understandings of the body/self were implicated in participants' ability to affect health behaviour change during postpartum. In doing so, I also problematise some of the current theorising about the inter-embodied nature of the mother and infant relationship during the first six months of postpartum.

### **7.2 Motivations for health behaviour change**

In this section, I begin by exploring how participants spoke about and described their motivations to engage in weight management during postpartum. As noted in Chapter 3, although it was not a deliberate sampling strategy, just under half of the participants ( $n=7$ ) were first-time mothers. In the following, I also draw on such distinctions to highlight some notable differences between the accounts of first-time mothers and those with children already.

### 7.2.1 “I might as well keep going”

The majority of the participants in this study expressed the intention to engage in weight management during the postpartum period. In fact many of these women expressed a desire to use the postpartum period as a ‘spring board’ from which to capitalise on the weight management successes of pregnancy. As described previously in Chapter 6, most women reported either losing weight, maintaining their pre-pregnancy weight (or returning to it shortly thereafter the birth) or gaining less weight than they had anticipated. In this regard Liz, mother of two, who reported losing weight during her pregnancy, offered a very typical account:

Liz: I was never wanting to be like this, you know, like so overweight and things but like I’ve said I’m not like hugely bothered because of appearance or anything like that but I’d like to lose weight now you know mostly ‘cos I kind of think well I should really now I’ve started (laughter) and like I’ve done a lot of the hard work already and now that I’m up and running I might as well kind of keep going, em but I don’t want to do it stupidly or I don’t want to do it really quickly I’d rather just kind of do it gradually over time. (Interview 1)

Liz’s account is interesting in that she can be seen on the one hand to acknowledge that she had never wanted to be overweight but, on the other, she deflects her concerns by suggesting that her appearance was something which she was not “hugely bothered” by, thereby positioning herself as having a rather nonchalant attitude to weight management. In a similar fashion, she described her motivations to engage in weight management in postpartum, with a tone bordering on indifference as her account is suggestive of an opportunistic approach to weight management rather than a strong resolve to actively manage her weight.

Unlike Liz who seemed to take a rather opportunistic approach to weight management during postpartum, other participants expressed being highly motivated to make health behaviour change. This was a particularly notable feature of the accounts of first-time mothers.

### **7.2.2 ‘Doing it for the baby’**

All the first-time mothers in this study expressed strong motivations to make health behaviour change ‘for the baby’ during postpartum. A number of the first-time mothers, for example, described becoming more aware of certain limitations posed by their large bodies and wanting to address their weight, as the inter-embodied tasks of first-time mothering challenged their bodies in unexpected and unanticipated ways:

Susan: I suppose I’ve just started to feel that because I’m overweight that it makes certain things that bit harder and I think I really need to do something about it. Like lately when I’m lifting him (son) and carrying him about and if you want to be out running and playing with him down on the floor all the time and when you are getting up and down and lifting him and that and when you are carrying extra weight it is that bit harder, if you like. I just don’t want it to be that way, you know? It’s things like when I go to baby massage group ‘cos I’m sitting on the floor and that’s fine but then when I get up I’m like oh my legs and my knees are really sore (laughter)! That’s not made for me I’m too big, do you know what I mean. I’m too big to be sitting on the floor and, do you know its things like that that make me think I need to lose a bit of weight. I didn’t really realise it until now looking back but I actually think when I was lighter, it was that much easier. (Interview 2)

In Susan’s account we see numerous references to the new inter-embodied and physical demands of mothering, such as carrying, lifting and playing with her son, as a time during which she has become more acutely aware that she was “carrying extra weight”. In this way, her account resonates with some of the findings presented in Chapter 5, where women described the impact of context, which at times prompted



individuals to become more aware of their weight. Indeed, Susan's account also touches upon the notion of a relational impetus to engage in health-related behaviours, as she described wanting to lose weight so that she could better meet the physical demands now being placed upon her as a mother. In this instance, she also seems to use the interview itself to reflect on, and explore, the changing meaning and understandings of her health and embodiment, brought about by her transition to first-time motherhood. This was evident in her iteration: "I need to lose a bit of weight. I didn't really realise it until now looking back but I actually think when I was lighter, it was that much easier".

Other women also suggested the transition to first-time motherhood prompted a desire to make the body more fit. Caroline provided an explicit example of this in the account below:

Caroline: I have always wanted to be slim and look good and wear smaller clothes during the summer and not be wearing tents and looking huge in every photograph taken and I would like to get back to that. I would like to be fit as well for him (son) because as he's been getting that bit bigger, you know, as the months go by and it's getting harder to carry him about the place and it's made me think too that in a couple of months' time he will be running about and he will need me to run after him (laughter), so I think that is probably a goal as well, you know, it is going to be better for him if I'm fit enough to run after him and do things with him. (Interview 2)

We can see from Caroline's account that she describes a shift from a previous engagement with health-related behaviours for largely aesthetic reasons, to a more relational, inter-embodied motivation, where she describes a desire to become more "fit" for her son. Arguably, by describing her intentions in this way, she can also be seen to position herself as a 'good' mother; that is, as a mother who aspires to make improvements to her health specifically to meet the (embodied) needs of her child.

Caroline's account also touches upon a conceptualisation of the body and health which is a multi-faceted phenomenon, meaning different things and experienced in different ways depending on the context or the social role demanded. For example, she makes reference to an aesthetic body, a body which she would like to be "slim" and "look good and wear smaller clothes". On the other hand, she also references a 'fit' and relational body, a body which can 'do' and 'act' within the context of mothering a growing child who is physically dependent on her to perform various bodily tasks. We can also see from her account that even within a relatively short timeframe (three months) with a baby who is now heavier to lift and with the future prospect of her son becoming more mobile, that Caroline has yet again begun to experience and conceive of experiencing her body in new and different ways. In this way her account can be seen to resonate with Scheper-Hughes and Lock's (1987) assertion that the body is entwined with context. It is here that we also see resonance with earlier discussions presented in Chapter 5, and that notion that postpartum represents a specific context, in which the body, health and weight may be experienced in different ways.

Aspirations to make health behaviour change were not only influenced by a desire to meet the corporeal demands of first-time mothering. Many of the first-time mothers also described a growing awareness of their large bodies in a very social and public sense, which prompted them to take stock of, and reconsider, their health and weight. This included Susan, who as you may recall from the opening vignette, described feeling a unique awareness and "pressure" as a large mother and the changing meaning that she herself and conceivably others now attached to her body. This shift was understood in her utterance:

Susan: I don't know before I had him I wouldn't have cared about what anybody else said, but when it comes to your child you do a bit, you don't want people to think that you're not doing the best for your child if ya like. (Interview 3)

Susan's account in particular references the highly public nature of both mothering and 'fatness', with the implication that the two together conspire to create a heightened sense of surveillance (being watched by others and of self-surveillance), which she articulates colloquially as "pressure". It could also be argued that in her evoking of "you don't want people to think that you're not doing the best for your child" and "nobody else probably thinks anything of it, but I think, they're thinking", we see a nod to Susan's internalisation of the "gaze" (Foucault, 1977).

Although Susan gave one of the most striking and obvious references to the notion of self-surveillance, other first-time mothers also described experiencing and perceiving a 'social gaze' in this way and suggested that this had further prompted them to want to lose weight. A pertinent example of this is provided by Emily in the account below:

Emily: It's more motivation now that I'll never put it back on again (weight lost in pregnancy) and I don't want to be one of these big mums you see going about the place, you know the ones that can't keep up with their kids and that has really made me more determined to get fitter and to lose weight and things like that. I want to be able to run after her and take her to the park and not be one of these mums that say well I can't chase after you. I want to be whatever she needs us to be. (Interview 1)

Like Susan, Emily also highlighted some of the moral aspects of mothering as a large woman and her desire (which she iterates twice in the aforementioned excerpt) not to be identified as "one of these mums" who, due to their size, would be unable to run after their children. Implicit here is the notion that her large body visually communicates something about her ability to mother well. For both Susan and

Emily, the “culture of a negative collective “knowingness” about fat” (Murray, 2005: 154), can be seen not only to communicate a ‘history’ of their own ‘fat’ bodies but by association, projects to the ‘future’ of their children’s bodies and draws upon the notion of an obesity “transmitted through lineages” (Goffman, 1990: 14).

McNaughton (2011) suggests that this discourse being so evident is not altogether surprising, in light of a “public health policy, practice and research” which “consistently” presents fat “as a looming threat to the health and wellbeing of children” with responsibility typically attributed to “inadequate or irresponsible parents”, who are stereotypically “cast” as overweight or obese mothers (2011: 180).

Mirroring some of the previous comments, Emily’s account also seems to highlight a shift in her identity defined by her new mothering role. In her iteration “I want to be whatever she needs us to be”, we see an eagerness and willingness (at least in the aspirational sense) to recreate aspects of herself to fit the demands of her new mothering role. It could also be suggested that she, like Susan and Caroline earlier, was positioning her own body in an instrumental manner, as a resource for whatever her daughter needs her to be (and do). In this respect, her account can also be seen to subtly and implicitly draw on a broader discourse around motherhood, in which a ‘good’ mother is one who positions herself (and her body) in highly sacrificial ways (Hays, 1996).

Other first-time mothers also described aspiring to make health behaviour change, specifically so that they could model what they perceived as healthy behaviours for their children. The desire to model healthy behaviours was largely predicated on the

perception that being overweight was viewed in a particularly negative light, as Alice so powerfully illustrates in the excerpt below:

Alice: I don't want her (daughter) to think it's ok to be bigger and to be unhealthy and things like that and that's my motivation to lose weight really because she is going to copy what I'm doing. If I'm big she's going to think it's okay to be big. I mean that was my whole reason to start being healthier is because I want to be a good role model for Lillie and before she was born it's been like well, what's the point we'll just kind of sit and we'll do it eventually or whatever but now I mean my husband has lost two stone as well, he was never really heavy, but I mean his BMI is now 25 and it was 30. Yeah, definitely we want to be good role models for Lillie and we're doing that consciously. (Interview 3)

For Alice and the other first-time mothers, the birth of a baby and transition to motherhood seemed to create an imperative for health behaviour change, at least in an ideological sense. This seemed to be premised on their views about the perceived influence and responsibility that mothers have for their children's health (Lupton, 2013; McIntosh and Zey, 1998). Interesting too, at least in the aspirational sense, is that these women seem to be positioning themselves as being very much in control of their bodies and appeared to want to embrace notions of individual responsibility, in their desire to demonstrate 'good' mothering.

It seemed that the transition to motherhood for the first time had, among other things, prompted a reconceptualisation of the meaning(s) women had previously ascribed to their bodies and health. In the analysis presented above, I have shown how both the physical demands of mothering and the first time transition to the mothering role seemed to prompt an awareness of a body, which, in the crudest sense, was no longer 'fit for purpose' and in ways, incongruent with their newly emerging self-identity. The differences between the accounts of first-time mothers and those mothers with

children already, could I argue, in large part be explained by the changes to one's self-identity such a transition to motherhood is purported to bring about (Oakley, 1980; Thomson, 2011). Sobal and Maurer (1999) observe that shifts in meaning are "especially evident during life transitions" and that it is often during these times that "our attention to body weight and appearance" (1999: 3) and health (Devine et al., 2005) are especially heightened. As argued previously, it is in this way that the transition to first-time motherhood could be seen to draw on aspects of the previous discussion on health (Chapter 5), in that it represents a specific context in which the body, weight and health became more 'presented' (Leder, 1990) and, at least for a time, it seemed to provide the impetus for health-related behaviour change. Albeit, as I go on to show this impetus did not necessarily translate into actual health behaviour change.

### **7.3 The gap between intention and reality**

Despite many of the participants articulating often strong aspirations to make health behaviour change and engage in weight management during postpartum, in practice those intentions rarely materialised. Indeed, the most notable change between interviews was often in the waning or cessation of plans for health behaviour change, or in the failure to instigate and actualise aspirations and intentions iterated in earlier interviews. Participants overwhelmingly (both implicitly and explicitly) indicated that the failure to actualise intentions between interviews could be accounted for by the unique inter-embodied demands of caring for a new baby.

In the following, I briefly show how the women I interviewed tended to depict the nature of their own (embodied) relationship with their infants in their day to day

lives. As I will go on to show, this provides as an important precursor to understanding engagements (or lack thereof) with weight management and health-related behaviours in postpartum.

### **7.3.1 Phenomenologically entwined bodies**

When participants described their day-to-day lives with their infants, they spoke about themselves and their bodies in ways which suggested that the body of the baby had become enmeshed with their own sense of self. As the following quote indicates, the manner in which these participants experienced the inter-embodied connection to the highly dependent body of the new baby, appeared to have a significant impact on what they were able to do with their own bodies:

Caroline: It's the fact that you can't be selfish anymore. I was always sort of a self-centred, not to a bad degree but I could jump in the car whenever. If I wanted to go on holiday or have a weekend away with my friends, I could. If I wanted to lie in, I could. My life was my own, the world was my oyster... I thought I was ready (to have a baby) like all through my pregnancy I was like I can't wait until he gets here and then right before the pregnancy I was like oh my god my life is going to completely change, and then when he was born I realised just how much of a change it is! Like you can't sleep in anymore, you can't go with your friends, you can't lie out in the sun all day reading a book. You can't read a book!! (laughter). But it's sort of countered with a lot of good things. But it's like that was my life as I knew it and it's just not anymore (laughter)...so I think that was probably the biggest change, the culture shock that you can no longer be a selfish person in anyway shape or form. (Interview 1)

In her account, Caroline can be seen to highlight an acute loss of autonomy and individuality, which she described colloquially as an inability to be "selfish" anymore. The loss of individuation was evidenced in her lament of a life she no longer considered her own, relegated to a time before the birth of her son, and

poignantly evidenced in her description of a series of activities she was no longer able to do.

Although Caroline's account highlights well this sense of loss of autonomy and individuality, in Susan's description below we get a much more tangible sense of how this shift manifested in embodied and practical ways. As Susan was a single, first-time mother who lived alone, in many respects the nature of her living situation exemplified the intensity and consumptive nature of the inter-embodied relationship between mother and child during early postpartum. In the following excerpt, she described her home life in the days following the birth of her son and recalled the first morning she was home alone to take care of him:

Susan: I think it was day five or day six but I remember my dad had a doctor's appointment or something and he hadn't been down to visit that morning and I had jumped in the shower, so I had his (the baby's) wee swing chair by the bathroom door, 'cos it was the first time getting a shower without someone being there to watch him and you're sort of keeping an eye on him and trying to jump in the shower while he's lying there and you keep sticking your head out, and everything and it was just crazy and I just remember, I was just sort of standing in the shower and I thought I'll have cereal when I come out of here and then I remembered awwhhh I've no milk! You know it was in that moment that I realised I can't even just nip to the shop for milk and that's when it sort of clicked I felt quite isolated, like quite trapped to find I couldn't get out of the house, like how the hell do I get out of the house? Later my mum had phoned to see how the wee boy was or something like that and I was like Mum, I just feel trapped in the house, I says, I think I'm going to get one of those like, you know those like baby carriers (sling) that you put on you. (Interview 1)

Like Caroline, Susan's excerpt offers a pertinent example of the unique, embodied dependency of the infant on the mother and how this reliance and inter-embodiedness fundamentally changed the way she experienced her own sense of self and body. When thinking about these restrictions and of the reliance and the constancy of the inter-embodied dependence of the infant on the mother, we can see



a certain loss of autonomy, as she described engaging in the care-taking tasks of mothering. In her own words, she characterised this embodied restriction as feeling “trapped” and “isolated”, as her own body became tied to the body of her son.

Arguably, this sense of interconnectedness of bodies is never more acutely empathised than when Susan suggested that she needed to purchase a sling with which to carry her baby, in order to restore some degree of autonomy to herself. Perhaps, too we see a subtle attempt to bring the body of the baby back into her own body, in ways which emulate aspects of the embodied experiences of pregnancy. Moreover, although both Caroline’s and Susan’s accounts can be seen to mirror Lupton’s (2012a) depiction of this inter-embodied dependency of the infant on the mother as one which fundamentally challenges the “ideals of autonomy and individuation” (Lupton, 2012a: 43), Susan’s account in particular hints at a more nuanced conceptualisation of inter-embodiment. For example, it is apparent from her quote above that her sense of autonomy and individuation was not only affected by the body of her son, but was experienced in fundamentally different ways in the absence of her father’s body.

I will continue to draw upon the notion of inter-embodiment in the following section as I explore how participants talked about their eating behaviours and engagements with physical activity during postpartum.

## **7.4 Eating**

The majority of participants in this study indicated that the transition from pregnancy to postpartum had resulted in significant changes to their eating behaviours. However, unlike previous studies which have positioned postpartum as a time in

which women experience positive changes in some food choice behaviours (Olson, 2005), most of the women in this study indicated that this transition had a negative impact on their eating behaviours. In the following I will attempt to unpack and explicate why this might be the case.

#### **7.4.1 Not having to say no anymore**

As discussed in Chapter 6, the majority of participants in this study described changing their eating habits during pregnancy and engaging in what Ettore (2002) calls “reproductive asceticism” (2002: 246). What I mean by this, is that they described stringently monitoring and controlling what they were eating for the health of the foetus. As highlighted earlier, such changes were almost exclusively fueled by anxieties around the potential risks what they were eating posed to the foetus.

However, as I began to speak to participants about their eating behaviours in postpartum, it became clear that, in the absence of such tangible and immediate risk to the foetus, the imperative to monitor and control their eating had significantly waned. Indeed, some women described looking at postpartum as an opportunity for ‘release’ (Crawford, 1984). One of the women who described experiencing postpartum in this way was Donna, a first-time mother who had lost eight kilos during pregnancy - a fact which she attributed to being vigilant about what she was eating. Like some of the earlier accounts, she also described wanting to continue to lose weight in postpartum and to capitalise on the successful weight loss she experienced in pregnancy. However, despite intimating a strong desire not to return to her previous weight, when I began to enquire about the practical steps (if any) she

had taken to ensure she maintained or continued to lose weight, she responded by saying:

Donna: You know I'm trying to get it back under control because I think it's a bit easy when you're first home and you're not having to keep an eye on what you're eating as much and like you don't have to be thinking about every last thing you're putting into your mouth but then you find you're just kind of gobbling everything. Yeah, so I am trying to get that back under control. (Interview 1)

What Donna's account touches upon is the notion that the intense period of control during pregnancy was for some of these participants followed by and experienced as release in postpartum. This is implicit in Donna's account of "gobbling everything" and her acknowledgement that she needed to get her eating "back under control". In particular she draws attention to a shift from what she saw as an imperative to 'keep an eye' on what she was eating during pregnancy, to the freedom which postpartum seemed to offer from those restrictions.

Other women also described experiencing postpartum in this way. One of those women was Bernie, who as you will recall from the material presented at the end of the previous chapter, had alluded to her fears about the impact the transition from pregnancy to postpartum would have on her eating habits. Over the course of the two succeeding interviews, while on the one hand continuing to express a desire to capitalise on the weight loss made in pregnancy, she also described being far less stringent about what she was eating than she had been in the previous nine months of pregnancy. In essence her fears expressed in the first interview did indeed become manifest:

Bernie: As I said I was wanting to lose weight but (laughter) instead I've gained weight...although I've not weighed myself I suspect that I'm heavier

than I was before I had her. I think you know part of it's the fact that I've been off sugary foods all that time that I'm like oh! there's so many things that I couldn't eat in pregnancy and now I can eat those things and you sort of subconsciously forget that I need to get going and the really funny thing now is that I'm actually missing that weekly clinic (laughter) because I suppose in a way it was disciplining me because somewhere in the back of my mind it was like yeah right I'm getting weighed I don't want to have put on loads and I'm missing that now and I was just saying that I know how the weight is creeping on and that's when I said to my husband that in a weird way I was missing the weekly weigh-ins at the hospital. He was like all you did was moan about them you hated it! I was like I know, isn't that weird I'm missing them (laughter) and I says maybe having somebody shout at me, not that they did shout but you know what I mean, maybe some unconscious part of my brain made me think no, I'm not going to eat that because I'm going to get weighed and the midwife will shout at me. (Interview 3)

Like Donna's earlier comment, we also get a strong sense that in the absence of the immediate and perceived risks associated with pregnancy, that postpartum was experienced as a kind of release. Moreover, she also specifically describes missing the external discipline and surveillance provided by the clinic during pregnancy and that, in the absence of those external 'checks', it was easy for her to "forget" about controlling her eating. Here we also get the sense, as with some of the earlier accounts of historical weight management (Chapter 6), that many of these women were positioning themselves as a kind of person who inherently lacked control, and who were in need of some kind of externally imposed discipline to successfully manage their weight.

Participants also described experiencing significant changes to their eating habits which they attributed to the unique, inter-embodied challenges the highly dependent body of an infant posed to some of the more practical engagements with daily life. It is to those aspects of my participant accounts I will now direct my attentions.

### 7.4.2 The inter-embodied impact on eating habits in postpartum

The inter-embodied nature of their relationship with the infant, above all else, was identified by participants as having a significant impact on their eating habits during postpartum. This was a particularly salient feature of the accounts of women who were breastfeeding:

Emily: She's at that age where she's really demanding and she either wants picked up a lot, like if I put her down in her chair and go to do something she'll have a little whinge, which makes it very hard for me not to pick her up. Or the other thing is that she wants fed all the time, so one way or the other I'm kind of holding her all day! It means that when you are trying to do things like trying to cook it's quite hard. So as a result we tend to eat later, like after 9pm, it's just not worth trying to sit down and eat our dinner at the same time! You know I'd like to be in a healthier routine but just at the moment I find I'm grabbing convenience foods, I'm not thinking about what I am eating as much I just eat something to give me the energy to care for her and feed her and things like that. I mean there is some things that I do, like I make sure I drink lots of water during the day just for her feeding and things like that but then other things like what I eat like during the day like you know just being like I'll just have a couple bits of toast or grab a couple of biscuits rather than saying I'll make a salad or something. I probably need to be stricter like that. (Interview 3)

Her response typifies other women's accounts during this period and highlights the inter-embodied nature of the relationship with the baby and the direct and tangible effect this had on her eating habits. In particular Emily suggests that the practical realities around breastfeeding and holding her baby, made it difficult for her to prioritise her own meals, leading her to snack throughout the day and to grab convenience foods which were easy and quick to prepare. In this regard, her account touches upon the very practical demands of caring for a baby and how her own, and often very basic needs, were affected and ultimately side-lined. For Emily, this was identified as one of the principal reasons why her weight had begun to "creep" back on during the postpartum period.

Conversely, for a number of women in the study, the shift in focus from their own eating behaviours to a more erratic eating schedule, which was now highly contingent on the baby, had resulted, rather inadvertently, in weight loss. Susan, for example, who had described her mealtimes as a central and pivotal feature of her everyday life prior to the birth of her son, suggested that since the birth of her son she had become less “obsessed” by her meals, in large part because she was consumed by the demands of taking care of her son:

Susan: A lot of people have said to me you’ve lost a lot of weight already from having him and I’m not trying that hard but I don’t know if you’re just not as obsessed with your food times or whatever...at the moment quite a lot of the time my mum will bring me down dinners and that (laughter) which is great, but especially in those first few weeks when everything was kind of chaos. So, I’m probably having a dinner which is good but like this morning I had cereal at ten or half ten or something like that but you do just more kind of grab stuff when he’s asleep, you’re not sitting down, but as I say because my mum makes me a dinner at night, it’s making me at least have a proper meal because otherwise I think I would just eat anything. I’d be picking all day and not really having a substantial dinner as such. He does seem to time it (wakes up), the minute that you go to eat your dinner!! (Interview 2)

Other women too not only described how the inter-embodied needs of the infant had affected their own eating habits but also drew attention to how the needs of other family members also presented challenges. Caroline provided a pertinent example of this in the account below:

Caroline: It is always in the back of your mind that you have to eat healthily. In the first six weeks you are struggling to throw a piece of toast down your mouth before the baby wakes up and wants something again, so for the first six weeks you do lose a lot of weight anyway, through the lack of sleep and the lack of routine...I mean I was living off coffee for most of the time, because I’ve lost 20 kilos since I’ve had him in the last six to eight weeks and that’s just because you have no routine, like I say, I mean Derick (partner) would come in and I would have to have his dinner ready but he has had a long day, he wants to go have a shower and eat his dinner in peace, so that is when I am getting the baby bathed and fed and stuff like that. I mean it is nine o’ clock when you are thinking I better have something to eat and you’re

like I'm not going to because I'm going to go to bed, so I'm not going to bed full, I'm going to bed hungry (laughter). (Interview 3)

What is significant about Caroline's account is that she touches upon the notion that her needs had become side-lined not only by the embodied demands of the infant but also by the needs of other family members. This is apparent in her account of preparing the baby for bed, whilst also ensuring that her partner's dinner was ready on his return home from work. As touched upon in the Chapter 5, participant accounts appeared to strongly identify 'good' mothering with the notion of putting the needs of others ahead of themselves. With respect to eating behaviours during this period, this can be seen to have a particularly deleterious effect, with participants articulating that they often prepared meals for other family members but then often did not eat with these individuals.

Other participants also articulated a much more complex notion of inter-embodiment when discussing their eating habits in postpartum. For example, for a number of participants, the lack of routine and predictability around the baby was further problematised by the bodies and routines of other members of the household. A pertinent example is provided by Liz who, in the account below, describes how her baby's lack of routine affected her eating habits which were also additionally complicated by her husband's work shifts:

Liz: It's like a double whammy with her routine and my husband's; it's really hard to get into any kind of routine with the way Matt (husband) works. He works different shifts so it is kind of tricky as every week is different. So like this week he is on day shifts which means he is away before we get up in the morning and he is not back until the kids are in bed so you pretty much have to do everything yourself. It's like I'm on my own all day, which is fine because he is back at night but he is off all next week so again next week will be completely different. Like I am quite bad if he is not here, like I will just not eat (laughter) and then I end up starving at about nine o' clock at night

and you are kind of like ah what can I eat now? If he is working day shifts he gets home about quarter past seven and I tend not to eat with my eldest and I will wait until he (husband) comes home but then it's like nine o' clock before you are having your tea, em but like the past few weeks I have been kind of trying to diet and so I have been more aware of it. I have just been eating before he gets back and he just sorts himself out when he's home 'cos quite often by the time he is finished a 12 hour shift he doesn't want to eat anything, so he is not really wanting a meal he just wants something quick and go to bed and that's it. In some ways it's easier when he's not here - at least me and the kids have our routine. I know that sounds terrible but it's just you never seem to be getting into a routine so it's quite tricky. I didn't actually think before about my routine as being so all over the place but it is (laughter). (Interview 2)

In Liz's account, in particular, we see that the body of her husband and his variable work shifts enables and disables different kinds of autonomy. For example, it is clear from her account that her sense of autonomy was experienced in very different ways when her husband was at home versus the times when he was not. This had notable implications for her ability to plan and manage her meals.

## **7.5 Physical activity in postpartum**

Participant accounts of physical activity over the course of the six months following childbirth resoundingly attested to low physical activity levels, with significant parts of the day purportedly being spent sedentary. Over the course of the six months, at no point could any of the participants be seen to satisfy the current physical activity recommendations for adults in Scotland, of at least 150 minutes (2½ hours) of moderate intensity activity each week (Department of Health, 2011).

In the following, I look at the ways in which these women talked about, described and conceptualised physical activity. Drawing once more on the notion of inter-embodiment, I also explore and explicate participants' accounts of their attempts to increase and sustain regular physical activity during postpartum.



### 7.5.1 “It’s just not the same thing as doing proper exercise”

For the majority of women I interviewed, when they talked about physical activity, they were in fact typically describing exercise, with the most common examples being; going to the gym and taking group fitness classes such as Zumba, swimming and boot camp. Moreover, descriptions of more recent engagements with exercise (that is, as opposed to the distant past, like childhood) were almost always exclusively linked to dieting and it appeared that these were activities which were rarely sustained (at least consistently so) outside of the parameters of weight loss. It is perhaps not unsurprising to find that when weight loss efforts inevitably waned, so too did more regular engagements with purposeful physical activity. In the excerpts below both Salma and Susan offer very typical characterisations of their involvements in physical activity (pre-pregnancy), which were reflective of the comments of the group as a whole:

Salma: I used to go to the gym because I wanted to lose weight but after I started working that all went downhill, it wasn’t something I necessarily enjoyed doing, I had a goal and I wanted to achieve that and so that has been my approach to exercise. (Interview 1)

Susan: I think I do just relate it (exercise) to the fact that you’re on a diet like if I go swimming or go to the Zumba class I don’t come out and go oh! I feel so much better for doing that I think oh! my god that was an hour of my life I can never get back again (laughter). See these people who get addicted to the gym, I would love to be one of them and I know I will never will be one of those people, I know it’s always going to be a chore and I will always come out thinking oh that’s an hour of my life I can never get back (laughter). (Interview 3)

Susan’s account in particular makes a direct link between exercise and being on a diet. Moreover, it was apparent from both of their accounts that exercise had little if

any intrinsic value - what I mean by this is that it was looked upon as providing a means to an end (weight loss) and did not appear to evoke any sense of enjoyment.

When participants spoke about being physically active during the postpartum period, they typically described engaging in household activities and walking. For the vast majority, these appeared to be activities which were undertaken somewhat incidentally and more often for reasons other than improving their own health. In this regard, Caroline offered a very typical account:

Caroline: You know I'm not much of a walker, like one of these ones you see pounding down the road with their arms swinging up and down (laughter). It's more that I walk to the shop and things like that, so mostly if I'm going somewhere, or to the health centre or maybe going down the golf club, we walk down there for something to eat or whatever. It's not really deliberate you know, especially with this weather as well. I mean you know I could take a nice walk up the forestry if it was the summer or something like that but I wouldn't do it in this weather. (Interview 1)

Unlike Caroline who described walking parenthetically, other women in the study indicated that they were being more deliberate about getting out to walk during postpartum. However, like Caroline, it was rare for these participants to describe being motivated by health reasons. One of the women who described walking more frequently during postpartum was Donna:

Donna: I wouldn't say I was a huge person for walks before but I've kind of got a purpose now to get out with her and get her some fresh air and not be stuck in the four walls...I'd feel a lot more cooped up and trapped if I didn't make myself go out because you know you hear people saying oh I never left the house for 6 weeks, so I always make an effort to go out every day. (Interview 2)

In Donna's account we do not get any sense that she was walking for health reasons, at least in the physical sense. In fact, like a number of other women in the study,

getting out to walk appeared to be employed as a tool to restore some degree of autonomy and assuage a feeling of being “cooped up” and “trapped” in the confines of the house. Donna also positions getting out to walk as benefiting the baby and getting her some “fresh air”. Finally, like Salma’s and Susan’s earlier accounts of exercise, Donna appears to look at walking as an activity which she has to ‘make’ herself do and not something she would necessarily choose to do normally.

While there was some evidence to suggest that participants were aware of the contemporary discourses which advocate the health benefits of being physically active throughout the day (Bailey and Locke, 2015; Dunstan et al., 2012; Peddie et al., 2013), these associations were tentative at best. In fact, a number of participants were quite dismissive of the health benefits of walking, which they positioned as a poor substitute for what they saw as “proper exercise”. Caroline, for example, who as you will recall earlier described herself as not being much of a walker, suggested that when she was physically active she liked to “feel the burn” and this appeared to be something she exclusively associated with taking fitness classes. In fact, she explained that she saw little benefit to walking: “what’s the point you know? It’s not going to burn off a bloody jaffa cake!”. Other women also gave similar accounts. One of those who shared Caroline’s opinion was Harjeet, who, in our second interview, indicated that she was “back on the wagon for losing some weight” but described her frustration at not being able to exercise and her reluctance to engage in other (lesser) forms of physical activity:

Harjeet: It’s really frustrating me that I can’t do exercise as well at the moment ‘cause the last time when I went on a big weight loss mission a couple of years ago I lost about four stone and I was going to so many exercise classes all over the place.

SC: Can I ask why you can't exercise at the moment?

Harjeet: Apparently I'm not allowed because it's my third caesarean and the stitches are not fully healed or something and I think I have to wait another few months before I can go back to proper exercise. I'm not too sure exactly but anyway I want to go back to Zumba but no, they said no Zumba, no nothing. The doctor says I can do gentle walking but you know stuff like that it's just not the same thing as doing proper exercise, so part of me thinks really, what's the point 'cause as well I've got so many other things to do. (Interview 2)

It is clear from both Caroline and Harjeet's accounts that they appeared to be eager to engage in exercise and that being physically active, at a lower intensity, was considered wholly insufficient, in light of the fact that they wanted to lose weight.

### **7.5.2 "I'm really just focused on the baby all day"**

As previously highlighted, the impact of sedentary behaviours on health has been well documented in the literature. For this group of women, not only were reported physical activity levels in general very low during the period of the study, but their accounts also indicated that this was a highly sedentary time - that is purportedly over and above the time they previously spent in these behaviours prior to pregnancy. This was a particularly notable feature of the first six weeks of postpartum, as women spoke of the need to rest and recover from the birth and of being exhausted, as their own sleeping patterns were now tied to the often erratic feeding and sleeping habits of the baby. During this time many of the women described grabbing naps during the day or watching television to relax on the occasions when the baby was sleeping or was being cared for by someone else.

A number of women also drew attention to the highly sedentary nature of infant feeding, especially breastfeeding, and of being consumed by and largely preoccupied

with feeding the baby for most of the day. This included Lisa, who breastfed her baby for five and a half months and who described a typical day as follows:

Lisa: Generally the pattern is we get up about ten and she'll feed probably reasonably constantly 'till about two or three in the afternoon and doing anything else in that time is pretty difficult. Em, but from then on out it's pretty much plain sailing. She'll sleep probably 'till about five, she'll maybe feed for a couple of hours on and off and then I'll have dinner and she'll chill out or maybe she'll sleep, well maybe she won't sleep (laughter) but she'll be calm and then probably about eight o'clock we'll start working towards getting her to go to bed and that's my day pretty much. Pretty much I feel like I am becoming part of the sofa, like I'm a feeding machine which is a different way to live as I'm really just focused on the baby all day. I'd prefer not to be that way, but I think it can't be any other way I would like be exercising more; but realistically it's just not feasible, it just can't be done. I am basically a feeding machine for her and that's it. (Interview 2)

In her description of a standard day and her depiction of herself as “becoming part of the sofa” and as a “feeding machine”, she draws attention to both the consumptive and the highly sedentary nature of her breastfeeding experience. It is clear from her account that she identified the inter-embodied aspects of breastfeeding as a significant factor in her inability to adopt certain health behaviours, such as “exercising more”. Also, inherent in this assertion is a conceptualisation of her body as primarily functional and instrumental, as she positioned herself as consumed by meeting the needs of the baby.

Apart from the inherently sedentary nature of breastfeeding, which she described above, she also drew attention to certain social and cultural factors around the acceptability of breastfeeding in public, which appeared to subtly impact on the likelihood of being more physically active throughout the day:

Lisa: I would never breastfeed in public, you know you've really got to be comfortable and you've really got to strip off and I've got to think about what I am wearing, like what I'm wearing right now, I couldn't breastfeed in front

of anyone unless I pulled it all up and then you've got this big belly hanging out and it's just, you just don't really feel particularly like, you don't feel normal. Yeah and I just feel like my boobs are so big, it's like I can't do it discreetly, I know that some woman could, but that's not (me)...And I think that's what it is, I just want to stay like a normal, civilised person who doesn't take their clothes off in public (laughter) 'cause it's like you wouldn't be expected to get your boobs out normally, so why is it any different just 'cause you've got a baby? It's a really weird thing, because psychologically all of a sudden you're meant to be ok with getting naked in front of everyone (laughter). (Interview 2)

Like Lisa, none of the other participants indicated that they were comfortable breastfeeding in public and described, what Murphy called the moral and “cultural obligation to protect others from exposure to breast feeding women” (1999: 204). Although, not immediately apparent perhaps, for all of the women in this study, breastfeeding became an activity which was almost exclusively carried out in the home. This had important consequences for physical activity as these women's bodies were now grounded within the confines of a small bounded space.

Moreover, it was apparent from Lisa's account that a significant aspect of 'breastfeeding' in public was the lack of acceptability of exposing aspects of her large body to others, especially her large breasts and “big belly”. Arguably by not breastfeeding in public, Lisa averts the unwanted gaze of others and in doing so maintains a sense of 'normalcy' as a “civilised person”. These findings mirror other studies, for example Keely et al. (2015) in a qualitative study which explored the factors that influence breastfeeding longevity amongst obese women, suggested that large women feel particularly vulnerable and self-conscious about exposing their bodies and were unlikely to breastfeed in public. Again such a dynamic has potential meaningful implications for engagements with physical activity outside of the home.

Other women too described rarely leaving the home and of being highly sedentary throughout the day. Some new mothers, for example, expressed anxiety about their ability to cope and respond to the demands of their baby in the event that they had to leave the house. Salma provided a pertinent example in the account below:

Salma: To be honest I've not been out walking at all, I've only left the house two times to run a quick errand when my mum was around to watch him. You know I've pretty much tied myself at home so I have with the baby, the poor thing honestly I need to get out and about. I have had leaflets today from health visitors and even she was saying you need to get out and be active and like I know I do, like I've wanted to go for walks and things but I'm just really scared of getting out in case he'd start crying or needed to be fed and what would happen if he wouldn't settle and do you know how would I deal with it on my own? Like when I am out and about and if he starts what am I going to do? So to be honest I've just chosen to stay in. (Interview 1)

It is clear from Salma's account that she was aware that she 'should' be more physically active but this was weighed against a strong reluctance of being away from home and being unable to cope should her baby "start crying". Although her account is unusual in the extent of the powerlessness she portrayed, it does, however, share strong similarities with the accounts of other participants, many of whom depicted the inter-embodied and capricious nature of life with an infant as restricting their ability to leave home and become more physically active during the postpartum period.

### **7.5.3 Attempts to become more physically active**

Over the course of the study, particularly when infants tended to be in more established routines, a number the participants expressed a desire to become more physically active. Similar to past experience of engagements with more purposeful physical activity, their motivations were almost exclusively driven by a desire to lose

weight. However, as I will go on to show, attempts to increase physical activity levels were mostly unsuccessful and, again, the most notable change between interviews was in the waning or cessation of plans for health behaviour change, or a failure to instigate and actualise intentions between interviews.

In the following, I explore some of the challenges which these participants described encountering when attempting to increase their levels of physical activity. Again, I pay attention to the embodied aspects of these accounts as these seemed particularly salient.

#### **7.5.3.1 “It's a fear that something's happening”**

For a number of women in the study their ability to engage in physical activity was notably impacted by their recovery from a caesarean section. This was particularly true over the first six weeks, which is the recommended recovery time for an uncomplicated caesarean birth (NHS, 2015). During a typical recovery time it is recommended that women avoid lifting heavy things and wait for about six weeks to resume gentler forms of activity, such as walking and swimming and to build up physical activity levels gradually (NHS, 2015). However, a number of women in this study described activity levels as being negatively impacted on far beyond the recommended six week period, despite being medically ‘cleared’ to resume activity:

Donna: I want to do it (return to the gym), I really do like as I've said that's my mission really but I'm just a bit scared because I like Body Pump but it's lifting weights and I'm just thinking of my scar and it's something I just have to get over and just do it. So like that is something I've just got to push myself to do it, so for now it's just like the walks I'm doing with her and then I've got to, because my friend, she's going back to gym and it's like oh! I hope we have classes together and stuff so that's my mission to get back because I mean the doctor was like oh it's all fine and stuff but it's just the fear because I lifted a box about a few months, about a month ago and it just



felt like a rip, so it's just that fear, it's a silly fear so it will be fine but it's a fear that something's happening. (Interview 2)

In her account, we can see that Donna positioned herself as having a desire to return to more organised physical activity but her experience a few months earlier of lifting a box and feeling an abdominal 'rip', had left her fearful and cautious of becoming more active. Donna can be seen to offer a highly embodied and largely subjective understanding of her recovery from her caesarean section – an embodied understanding which she clearly used to inform her decision to continue to limit her physical activity during this period. Donna can also be seen to express a certain amount of resistance to medical guidelines, intimating that she would have to “push” herself to remain compliant with medical opinion. Moreover her fear of “something happening” appears to reflect uncertainty and lack of control over a body she cannot, at least for the moment, trust.

#### **7.5.3.2 Inter-embodied dynamics**

A number of participants' descriptions of their attempts to increase physical activity specifically drew upon some of the inter-embodied aspects of caring for an infant.

An example of this was provided by Liz, who in our second interview together described a particularly stringent diet, which she had begun a month earlier. At that time she had also described her plans to begin increasing her physical activity levels. Although she suggested that she would have preferred to take exercise classes she felt that was not possible now with two children and her husband's variable work shifts. Hence, instead she said she had planned to get out and walk a lot more.

However, when I returned to visit Liz for the final interview, she not only described a

very typical trailing off of her diet which was reminiscent of the earlier accounts of cyclical weight management, but also some of the barriers she had encountered in her attempts to become more physically active:

Liz: yeah the diet didn't last very long (laughter)! Up until the summer I was really fine and then it wasn't until like kind of when the summer holidays started and we went away for a week and then with Patrick (four year old son) being off as well so it was kind of like trying to find things to do and occupy yourself, going to softplay and sitting with like all your friends sitting and have a coffee and bacon rolls and it was like ohhhh who cares about the diet.

SC: I know in the previous interview you also mentioned planning on walking a bit more, how has that worked out for you?

Liz: Like in my head when Patrick started school I thought it would be great 'cos we will be able to walk down in the morning and walk back up. But Patrick can't cope with it, he's exhausted, like school is really taking it out of him. We did walk down to school a couple of days but by the time he got there he was just knackered. So, now we take the car down in the morning and in the afternoon sometimes I will walk down with him at the beginning of the week. I am more likely to walk down with her (baby) in the buggy and pick him up but by the time he gets to Thursday he is just pooped and I think it is just not worth the argument. (Interview 3)

Liz's account highlights the complexities of managing two children and getting out to walk, which at six months was the only apparent physical activity in which she was engaging, apart from housework. In this way she not only highlighted the inter-embodied dynamic between the mother and infant as being significant but also pointed to a much more complex and nuanced inter-embodied relationship. By this I mean a notion of inter-embodiment which involved other bodies and shifting contexts (in this case her son starting school), which presented significant practical and often unforeseen challenges to her ability to engage in more frequent and routine physical activity.

Other women too described encountering certain unique, inter-embodied and unexpected challenges when attempting to become more physically active. One of those women was Bernie, who despite articulating a desire to manage her weight during postpartum, reported gaining weight during this period. In our final interview she discussed her recent attempts to begin addressing her weight gain and her interest in becoming more physically active. In the following excerpt she described one of the first evenings she had left her husband alone to take care of the baby. She mentioned that since her baby was breastfeeding less, in theory this had freed her up to attend an exercise class in her local village:

Bernie: It's funny because she (the baby) has a bit of fractious time every night between half six and half eight where she's just not very happy and stuff and I think she's just a bit overtired. Because she's feeding less and less I have been able to get out a couple of times in the evening so I decided that I'd like to try out this class (exercise) in the local hall but like when I've come back from the class the boys have met me at the front door and they were like the baby has been crying since you left, she has been crying for two hours you know and they're like 'oh Dad's walking up and down with her he's not very happy he keeps shouting at us' (laughter) and I've come in and lifted her out of ...

SC: Your husband's arms...

Bernie: Yes, and you know it's been immediate silence (laughter). All of a sudden she's quite happy. Yeah and my husband gets all 'awh yeah, she doesn't like me! What's wrong with her? I can't seem to settle her!' (laughter) I'm like, yeah, that just 'cos she wants her mummy so yeah, I does make it a bit hard to leave her and go and things, so I might need to leave it for another bit. (Interview 3)

Bernie's account in particular draws attention to some of the less obvious challenges inherent in leaving her baby, even when suitable childcare was available.

### 7.5.3.3 'Good' mothering

Other women also described their attempts to increase their physical activity levels during postpartum but positioned their desire to be more physically active as competing with notions of 'good' mothering. One participant who described her experience in this way was Mel, who in the account below recounted her failed attempt to attend a weekly swimming class:

Mel: I tried to go back to swimming and things and then but I think I tried, I tried to change my eating by cutting back on all the junk food especially at night when the kids go to bed and started going back to swimming but I did it all in the same week. I felt good that week but then I went and I got her (the baby) weighed and that's when there was like a huge drop in her weight and so I was like okay maybe I've done too much and then I felt bad like guilty that she wasn't being properly taken care of, that she wasn't getting enough milk, even though I know it was probably just a growth spurt and it's not like I had just left here there without any milk (laughter) but still I found it hard not to blame myself so I've been like okay well now we are just going to wait and see, yeah so I am still trying to eat healthy but I've not gone back swimming. (Interview 2)

Although she had expressed enough milk for feeds for the period she had planned to be away, nevertheless it was apparent that she had a difficult time not taking blame and feeling guilty for the dramatic drop in her baby's weight. What Mel's account touches upon, particularly in her decision not to go back to the class, is the strong mothering discourse which positions a 'good' mother as one who places the needs of her children ahead of her own. In this way we can see a contradiction and tension between the imperative to health (Petersen and Lupton, 1996) which requires one to invest considerable time and energy in the pursuit of health, and on the other hand, 'good' mothering discourses which emphasises self-sacrifice (Hays, 1996).

Other women, particularly first-time mothers, described a process in which they were ‘learning’ to re-prioritise their own needs in the transition to motherhood. In this regard Caroline gives an account of her attempts to go to the gym and her subsequent realisation that she needed to reconsider those goals, in light of the challenges and expectations associated with motherhood:

Caroline: I’m learning not to try and do so much and I’m learning about what is more important to prioritise like I suppose you learn not to expect to get much time to focus on yourself and you need to go with that, you know just get on with things and that for now it’s all about the little man...like I had high hopes of going to the gym but it is not so much a priority now like I will go if I can go if there’s childcare and if he’s in good health and if he’s not well then I won’t go, I mean I could leave him with my dad or Derick (partner) but if he’s gurney like this I don’t think that would be fair and obviously everyone wants their mum when they are not well and that’s just the way it is. (Interview 3)

Caroline’s comment clearly demonstrates some of the fundamental aspects of modern mothering discourse. The first is that it is primarily the mother’s responsibility to take care of children. Secondly, her excerpt shows the pervasiveness of this discourse by her assertion that “obviously everyone wants their mum when they are not well and that’s just the way it is.” Again, like Mel’s earlier account any desire to pursue her own goals, such as attending the gym are considered to be in conflict with her responsibly and duty to care for her child.

No doubt one could argue that by drawing on ‘good’ mothering discourses in this manner, some women might be viewed as attempting to save face by “bridging the gap between action and expectation” (Scott and Lyman, 1968: 46). Arguably too, one has to question whether these women were using a discourse of ‘good mothering’ to provide justification for something which they felt under pressure to do but did not actually want to do. However, I tend to agree with Pill and Stott (1982) who, in a

study which explored the accounts of UK working class mothers' concepts of illness causation and responsibility, similarly found that the mothers more often described placing the health needs of other family members above their own. The authors go on to suggest that it was not beyond the bounds of possibility that these women were "over-dramatising their role as lynch-pins of the family without whom everything would collapse", but that they appeared (as my participants did) to perceive those pressures as being "very real" (Pill and Stott, 1982: 50).

## **7.6 Commentary**

This chapter has demonstrated some of the complexities surrounding both the intentions to engage in certain health-related behaviours and the practical realities surrounding those engagements in postpartum. In doing so, I have built upon earlier discussions, for example, the previous accounts of approaches to weight management which were useful in explicating and understanding certain approaches to weight management in postpartum.

Moreover, I have also used the participant accounts to enhance and extend the notion of inter-embodiment within the context of motherhood. I have for example shown how it was not just the body of the baby but the bodies of other family members which had a noble impact on the mother's sense of agency and autonomy. My discussion in this regard illustrates the necessity of accounting for the embodied aspects of mothering (Doucet, 2013; Doucet, 2015) if we are to more fully and fruitfully explicate and gain an understanding of engagements with health-related behaviours during this period. This will be revisited and explored more conceptually in Chapter 8.



## **Chapter 8: Discussion and conclusion**

### **8.1 Introduction**

In this discussion, I aim to bring together some of the more important findings and ideas from the preceding chapters and discuss them within the context of the existing literature. In particular, I will highlight how my work furthers understandings about the complexities underlying engagements with health-related behaviours and weight management in postpartum, for large women. Crucially, throughout this discussion, I draw upon the relational and inter-embodied aspects of women's accounts where I argue that the bodies of others played a significant role in shaping how my participants perceived and experienced their own bodies and health. Finally, the chapter culminates with a discussion of the study limitations, implications for practice and possible avenues for future research.

### **8.2 Embodied accounts of health**

As discussed in Chapter 5, contrary to popular constructions of large individuals as unhealthy (Gard and Wright, 2005; Monaghan, 2008), most of the women in this study positioned themselves as being in 'good' health. Their accounts strongly resonated with the notion that, when speaking about their health as large women, many appeared to be actively positioning themselves as "worthy individuals" (Radley and Billig, 1996: 220) and, in doing so, highlighted an acute awareness of the moral discourse surrounding the relationship between weight and health. Echoing the tenor of other studies, my participants drew heavily upon biomedical discourses to both demonstrate and rationalise their health as large women (Tischner and



Malson, 2012; Tischner, 2013). For example, they did this by suggesting that they had normal blood pressure, good cholesterol and that they rarely sought or were in need of medical attention.

Perhaps not surprisingly, there was also a strong experiential aspect to these women's accounts of health, which seemed to have the effect of 'grounding' health very much in the present, and there was little, if any, engagement with notions of risk or future risk. My participants, for example, resoundingly conceptualised health as the 'absence of illness' and notably as 'good enough' in the absence of *significant* physical encumbrance and the ability to undertake everyday activities (including mothering) without undue discomfort or difficulty. In addition, despite my participants articulating an awareness of public health and biomedical discourses which frame overweight as 'risky' to long-term health, it seemed that in the absence of a subjective, embodied experience of illness or struggle, few felt any impetus to engage in weight management for the purpose of improving their health. In this regard, Bury's (1991) concepts and ideas about chronic illness are useful in thinking about and understanding my participants' accounts, in particular his suggestion that the meaning of illness is perhaps best understood by looking at the "*consequences for the individual*" (1991: 453). Other studies too have reported similar findings. In a qualitative study which explored understandings of health amongst younger and older people, Lawton (2002) argued that it was the "experience of embodied ill-health", over age, "that prompted people to perceive themselves as directly vulnerable to the threats of future morbidity and mortality" (2002: 719). Like my participants, Lawton's respondents approach to health behaviour change tended to be 'reactive' and engaged with in response to an experience of ill-health, above a

proactive and preventative impetus. In this way, my respondents accounts demonstrate what Lawton (2002) describes as the “complex ways in which dominant health and risk discourses are mediated – and often muted by – people’s every day, lived experiences of embodiment” (2002: 727).

My findings also complicate Lawton’s (2002) findings and lay challenge to Leder’s (1990) earlier contention that bodily awareness (and by implication, health) typically occurs at times of ‘dysfunction’ (illness or physical pain). Indeed my participants’ accounts also highlight the importance of context in mediating and informing how these mothers experienced their bodies and viewed their own health. This was demonstrated in Chapter’s 4 and 5 where some participants described rather mundane, everyday experiences such as trying to find a bus seat which they could comfortably sit in, which subsequently brought about a corporeal awareness and a desire to lose weight. Again in Chapter 7, the role of context in mediating experiences of the body and health was highlighted as first-time mothers in particular, indicated that the physical demands of taking care of an infant and the transition to their mothering role had the effect of foregrounding (both in a physical and social sense) their large bodies, at least for a time. Again this prompted some women to reflect on their own bodies/health and consequently to want to address their weight. Indeed, Angus et al. (2007) suggests that changes to place (both physical place and social position) can impact health and prompt a “creative revision” of the relationship to the body (2007: 1095). Indeed, these authors argue that engagements with health-related behaviours are “enduringly” associated with contexts, suggesting that “place, body, and health are inseparable and co-constituted” (Angus et al., 2007: 1095).

As I have described above, my participants most often conceptualised health as experiential absence. Indeed, it has been long argued that the conception of health as both the ‘absence of illness’ and the maintenance of a functional and instrumental body<sup>25</sup> is largely a working class preoccupation (see Blaxter, 1983; Blaxter and Paterson, 1982; Pill and Stott, 1982). This is a view which touches upon Bourdieu’s (1977) theorising of the body as ‘physical capital’ and similarly, d’Houtard and Field’s (1984) insights drawn from a large scale survey, which looked at perceptions of health amongst different social classes in France. Both attributed much more functional definitions of health to those from working class and manual backgrounds with those from the middle classes situating health in a more aesthetic paradigm. However, Calnan (1987), in a comparative study which explored differences in conceptualisations of health by class in the UK, cautioned against generalisations founded on class-based distinctions. Based on the findings of interviews conducted with 60 women aged between 21 and 55 years<sup>26</sup>, he suggested that both working and middle class women, tended to view health similarly as the ‘absence of illness’ and functionally, as being able to ‘get through the day’. Indeed, as I have highlighted in Chapter 5, participants in my study, who came from diverse backgrounds, also appeared to share remarkably similar conceptualisations of health. Amongst the cohort of women in my study, definitions of health as primarily functional and instrumental, appeared consistent with an embodied approach to ‘good’ mothering.

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<sup>25</sup> An instrumental/functional definition of the body is one that views the body as a ‘means to an end’ rather than an ‘end in itself’ (Shilling, 1991: 130).

<sup>26</sup> In Calnan’s (1987) study he was concerned with exploring conceptualisations of health between women from different social classes and did not look at possible differences arising between women of different age groups. Therefore, it is not beyond the bounds of possibility that conceptualisations of health as the ‘absence of illness’ could have been shared *more* predominantly amongst younger members of his study sample, who may have been more likely to take certain aspects of their health – and bodily ability to do things – for granted.

What I mean by this is that my participants consistently described their approach to mothering as one which necessitated that they position their bodies and health in highly sacrificial ways. Such an approach to the body and health was demonstrated by participants at various junctures throughout the findings chapters. For example, in Chapter 4, a number of participants identified the neglect of one's own health as a 'good' mothering 'trait' which they indicated had been passed down from the previous generation. In a similar vein, a number of first-time mothers pointed to their transition to motherhood as a time in which they were 'learning' that they now needed to prioritise the needs of the baby (and often those of other family members) over their own needs. In Chapter 7, first-time mothers in postpartum also described a strong impetus to engage in weight-management 'for the baby', above any intrinsic desire to engage in such health-behaviour change for themselves and their own bodies/health. Indeed, many of the women in this study described wanting to role model good behaviours for their child and to embody 'good' mothering by making their bodies more fit to meet the physical demands of taking care of an infant. These findings also resonate with those reported by Edvardsson et al. (2011) who undertook a qualitative study in Sweden of first-time parents (none of whom were considered by the interviewer to be obese) and similarly highlighted that it was parents' perceptions (particularly the mother's) about possible risks to their children's health which appeared to be the primary driving force over any intrinsic motivation to engage in health behaviour change. Of course, it could be argued that such motivations are not simply the result of an intellectual desire to be a 'good' mother but are in fact reflective of a fundamental change in how women viewed and experienced their bodies within the context of postpartum. Other studies too have

noted similar shifts in embodied experiences in postpartum women. Bailey (2001) in her account of British middle-class pregnant and postpartum women found that some of the women reported looking at their bodies in much “more functional terms” and that the descriptions offered both during pregnancy and postpartum “stressed the connection between their bodies and the needs of their babies” (2001: 120).

Similarly, Fox and Neiterman (2015) in a qualitative study which set out to explore Canadian women’s feelings about their bodies in postpartum, noted that women seemed to identify with what the authors termed their “maternally functional” bodies (2015: 681). The authors went on to suggest that for some women this afforded them the opportunity to experience their bodies in much more positive ways and “overrode upset about appearance” as they described feeling a sense of accomplishment and empowerment as they ‘used’ their bodies in new ways to meet the needs of their baby (i.e. breastfeeding) (Fox and Neiterman, 2015: 681). For some women this afforded them the opportunity to experience their bodies in more positive ways. Moreover the authors suggested that positive associations with the maternal body were evident even when women talked about “prioritising their own care, through body work, many did so in the name of maternal responsibility” (Fox and Neiterman, 2015: 689). I suggest that, taken as a whole, my participants’ accounts demonstrate an embodied and instrumental view of the body as being tied to the ‘good’ mothering role (amidst other roles and social obligations), perhaps above and beyond a specific class-based conceptualisation of health, at least at this point in the life course.

### **8.3 Bodies in relation**

Conceptualisations of health, body size and health risk were not entirely based on the experiences of the individual self. Indeed, as touched upon in the previous section when discussing the notion of the “maternally functional body” (Fox and Neiterman, 2015: 681), my analysis suggests that the bodies of others played a crucial role with respect to how my participants understood and experienced their health and bodies. The importance of the bodies of others was particularly evident in Chapter 4 where I reported that the majority of my participants located the genesis of their body size in relation to other close family members. My participants also made reference to other bodies, such as the bodies of other large women who they encountered within their social networks. For example, in Chapter 5, my respondents highlighted the possibility of good health for large women (and therefore themselves) by making reference to the bodies of other large women who they positioned as being active and healthy.

My findings regarding how my participants used the bodies of others to make sense of aspects of their weight and health, also contributes to existing literature which has looked at lay notions of health and illness and, in particular, how people draw conclusions about their own health risk, in part by making assessments of those around them. For example, in a seminal paper Davison et al. (1991) coined the phrase ‘lay epidemiology’ to describe the process by which individuals assess their likelihood of developing heart disease by drawing on their own lay stock of knowledge based on observations of people within their social networks. Although Davison and colleagues acknowledged that lay notions of illness and risk were

constructed in ‘relation to others’ and argued that people tended to assess risk (in part) by making reference to the “physical appearance” (1991: 11) of others, nevertheless the role of the body and other bodies remained rather implicit. Jenkins et al. (2013) argue also a similar point, suggesting that when relations to others have been recognised in current theorising in the area of illness biography and more recent research looking at the social dimensions of genetic identity, that there has been a tendency to focus on “relations between selves as opposed to bodies” (2013: 530).

I would argue that the findings of this study suggest the role the bodies of others play in lay assessments of health risk should be given much more explicit consideration. Indeed this may have some notable implications particularly when we consider the rising prevalence of overweight and obesity amongst families and the prospect that individuals will increasingly engage with other large bodies within their social networks. As lay ideas about what constitutes ‘ideal’ body weight inevitably shift as a result, it seems probable that individuals will experience their bodies/weight and make sense of their health risk in different ways.

The notion of relationality and the role of the bodies of others, particularly the interweaving of the bodies of the mother and infant, will be extended further in the discussion below.

#### **8.4 Looking at health-related behaviours in postpartum through an inter-embodied lens**

Undoubtedly, one of the most significant contributions this thesis makes is in highlighting how women’s inter-connectedness with other bodies (particularly the highly dependent body of the baby) mediated engagements with certain health-

related behaviours during the postpartum period. This marks a departure from the current literature on mothering, where, as I addressed in Chapter 2, “little explicit and implicit attention” has been given to the issue of embodiment in parental care work in day-to-day contexts (Doucet, 2013: 287). As a consequence, the body in daily life and the body in relation to others has also remained notably absent in discussions on mothering and health.

The concept of inter-embodiment I use here is one which draws on Merleau Ponty’s (1962) account of the ‘lived body’ and the idea the lived experiences of one’s own body are “mediated” and informed by the presence of other bodies (Weiss, 1999: 5). It is a relational concept which emphasises the role of social interactions in knowledge production, posing that knowledge is not created within a single, autonomous body, but generated through our intermingling and engagement with other bodies (Springgay and Freedman, 2009). As a concept, inter-embodiment seemed particularly salient when attempting to make sense of and understand my participants’ accounts of their day to day life with an infant.

To begin with, as described in Chapter 7, my participants’ accounts suggested that for them, the dependent body of the infant had in many respects become enmeshed with their own sense of self and had a notable impact on what they perceived they could ‘do’ (independently) with their own bodies. As highlighted earlier, this mirrors Lupton’s (2012) description of the entwining of the bodies of mother and baby – an inter-embodied dynamic which, she suggests, presents a notable challenge to notions of “autonomy and individuation” of the mother (2012a: 43). Here, we see also see interesting parallels with Lawton’s (2000) work on the experience of individuals



dying in palliative care settings. In her account, Lawton comments on the ways in which the highly dependent bodies of the terminally ill person can impact on those involved in their direct, 'hands-on' care – that is, carers (often family members) who were responsible for the washing, dressing and lifting the highly dependent bodies of others. These are corporeal demands which are similar to those placed on mothers taking care of infants. In becoming an agent of another's "bodily actions", mothers, like the carers in Lawton's study, described how their own sense of self/body became "grounded in, and constrained by, the immediate physical requirements" of another body (Lawton, 2000: 107). Indeed in her study, Lawton described how the body of the patient became so "closely enmeshed" with their carer's "sense of self" and that such engagements with 'dependent' bodies presented "situations wherein the self (in these interactional moments at least) is not always and necessarily singular, unified and self-contained within the parameters of an 'individuated' body" (2000: 108). In essence the selfhood of the carer, or in this case the mother, is experienced "within two bodies" (2000: 108).

This notion of selfhood being experienced within two bodies became very apparent when my participants described their engagements with health-behaviours during postpartum. For example, participants described how their own behaviours in this regard were highly contingent on the baby. For example, many of my participants described trying to negotiate their mealtimes around the baby's sleeping and feeding routines. This was a particularly salient feature of the accounts of women who were breastfeeding, as they described being largely consumed and preoccupied with feeding for most of the day. Most of these women suggested that such an inter-embodied dynamic lent itself to snacking and grabbing food whenever they could

and had also resulted in a heavier reliance on convenience foods, such as ready meals, pizzas and snack foods such as biscuits, which could be easily prepared and/or quickly consumed.

The intertwining of the bodies of the baby and the mother also had a notable impact on engagements with physical activity as my participants' accounts resoundingly attested to low levels of physical activity with large parts of the day spent being sedentary. Indeed, the limited qualitative studies which have looked at engagements with health-related behaviours in postpartum have tended to do so in reductionist and disembodied ways, and, I would argue, have failed to provide contextually based, descriptive and theoretically engaged findings. For example, one of the most commonly reported barriers to physical activity in the postpartum period is 'lack of time'. For example, Evenson et al. (2009) in a study which looked at the physical activity beliefs, barriers and enablers among 667 postpartum women at three months and 12 months postpartum, found that the most common barrier to physical activity was insufficient time and childcare issues. Interestingly, however these researchers also reported that amongst their respondents the most significant change in perceived enablers to physical activity from three months to 12 months could be accounted for by what they termed - "baby reasons that affected the mother" and gave the following examples: "baby older, healthier, not breastfeeding, more active" (2009: 1929). I would argue that these factors, although largely overlooked by Evenson and colleagues (2009) in their discussion of their findings, nevertheless hint at a much broader discussion - namely the importance of the role of inter-embodiment to understanding engagements with health-related behaviours in postpartum.

My findings not only point to the utility of the concept of inter-embodiment to understanding engagements with health-related behaviours in postpartum but my analysis also extends the existing (albeit limited) use of the concept in the mothering literature. To date, when the concept of inter-embodiment has typically been utilised within the existing mothering literature, it has tended to be employed to highlight and demonstrate the closeness of the bond, the ‘at oneness’ and intensity of the relationship specifically between mother and child (see also Lupton, 2012; Westfall, 2006; Wynn, 1997; Young, 1990). For example, inter-embodiment has tended to be used in pregnancy to describe the embodied relationship between the mother and the foetus and in postpartum, almost exclusively to refer to certain caring practices associated specifically with mothering an infant, such as “breastfeeding, cuddling, rocking and co-sleeping” (Lupton 2012: 47). It is in this way that inter-embodiment has been used to highlight how the entwining of the bodies of mother and baby (and associated care practices) present a challenge to notions of “autonomy and individuation” for the mother (Lupton 2012: 47).

However, when my participants spoke about their daily lives and their engagements with health-related behaviours, their accounts also alluded to more complex notions of inter-embodiment by suggesting that their sense of autonomy was further complicated by the bodies of other family members. As highlighted in Chapter 7, one participant described how her husband’s variable work shifts seemed to both enable and disable different kinds of autonomy and that, when he was at home, it often proved disruptive to her ability to manage her own eating behaviours. In this way, the concept of inter-embodiment might be more fruitfully understood by drawing on Jeanette Pols (2006) analysis of patient bathing practices in long-term mental health

institutions. In her account, Pols suggests that the different bathing practices reflect differing notions of citizenship and autonomy and makes a convincing argument that autonomy is not a word with one meaning, but takes up different meanings depending on the way it is enacted. This can be seen to contrast Lupton's (2012) notions of autonomy which seem to imply a continuum of more versus less autonomy, and one which only considers the bodies of the mother and the infant. If we return to the previous example, it was clear that for many of these women their sense of autonomy could be experienced in very *different* ways and that the presence of other bodies (for example a partner) did not necessarily mean a greater sense of autonomy. By employing a more expanded notion of inter-embodiment, we can see how even when suitable childcare options were available, which in theory potentially afforded the mother a greater degree of agency and the opportunity to leave the home and engage in physical activity, that it was far from straightforward. Here it is perhaps useful to consider Doucet's (2015) recent work on parental responsibility where she argues for a conceptualisation of parental responsibility that "shifts away from time and tasks" because of their complexity, embodied and "intrinsically relational character" (2015: 237). If we can begin to look at the nature of care work in postpartum through an embodied lens, in essence 'begin with the body', we can begin to conceive of care work (associated with mothering) not as a discrete set of tasks but wholly as an inter-embodied, relational practice with significant theoretical and practical implications.

## 8.5 Body projects

As described in Chapter 2, in the context of contemporary discourses of the ‘obesity epidemic’, the large body is typically framed as a consequence of individual lifestyle, determined by what one is eating and engagements with physical activity (or lack thereof) (Saguy, 2013; Saguy and Riley, 2005). In short, responsibility for body size and weight is most commonly positioned as lying with the individual<sup>27</sup>. Yet, perhaps in resistance to these discourses, notions of individual responsibility for body weight and size were strikingly absent from my respondents’ accounts. Although many of the women did indeed acknowledge certain lifestyle factors and behaviours as influencing their size, these associations seemed tentative and were often positioned as being mitigated by other, more salient factors. For example, as highlighted in Chapter 4, one of the principal ways in which participants discussed the genesis of their size was by drawing on lay notions of inheritance. By indicating this logic, many of these women seemed to be implying that their weight and body size were predetermined and only “peripherally affected by lifestyle factors” (Davison et al., 1989: 338). Furthermore, it could be argued that the lack of personal responsibility for body weight and size could at least be partially explained by the perceived discredit (Goffman, 1968) and perhaps sense of failure that such an admission might bring.

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<sup>27</sup> I acknowledge that there are competing discourses which emphasise the structural explanations for obesity (i.e. the notion of obesogenic environments). In theory these discourses deflect blame from the individual, however they have also been heavily criticised for feeding into the very individualist paradigm they mean to replace (see Kirkland, 2011).

Whilst participants drew upon lay notions of inheritance to suggest a predisposition to overweight, they also implied a certain irreversibility and permanence to their size and weight, which seemed to explain, in part, why previous and even future attempts at weight management were likely to be wholly or partially unsuccessful. These findings concur with those reported by Wills et al. (2006) in a study which explored young teenagers' perceptions of their own and others' bodies. These authors found that for some of the respondents, the notion that "individual efforts" could change body size was positioned as unlikely, in light of a genetic predisposition to particular "familial body shapes" (Wills et al., 2006: 400). The notion of 'fat' as a 'default' or 'natural' state among my participants was in a sense further corroborated by the material presented in Chapter 6, where participants described their engagements with repeated cycles of weight loss and gain and as I have argued, seemed to be indicating that losing weight was only ever a 'temporary' state. Some of these participants also seemed to view themselves as lacking particular traits or qualities which engendered one to self-control and in doing so it could be argued were subtly distancing themselves from personal responsibility for weight and size.

I would argue that these findings also enhance Shilling's (1993) concept of "the body as a project". As discussed in Chapter 2, the notion of the body as a 'project' refers to the idea that individuals (in postindustrial Western contexts) are engaged with "strict regimes of self-care" in the pursuit of a slender and toned body (Shilling, 1993: 5). The accounts of my participants, however, at times laid challenge to the notion of the 'body as project'. Indeed, a successful 'body project' for many of these women in my study did not seem anchored in normative ideas around a desire for slenderness, but a 'mediated body project', where, for example, understandings of 'appropriate'

weight-loss and size were influenced by lived experiences and were highly divergent from both cultural and biomedical ascriptions of what the body should look like. For example, as highlighted in Chapter 2, the idea that these women felt a ‘pressure to return’ to their bodies in the postpartum period, which has been ubiquitously positioned in the literature as a central concern for women following childbirth (Dworkin, 2001; Cunningham, 2002; Upton and Han, 2003; Dworkin and Wachs, 2004; Ogle et al., 2011), was notably absent from my participants’ accounts. In some respects it could be argued that for many of my participants their bodies had already in a sense been ‘returned’, in light of the fact that many had lost or gained minimal weight during pregnancy. However, overall their accounts seemed to indicate that many were ‘opting out’ of the prescribed discourses around shape and size. Crucially, I would argue that any seeming contradiction between positioning one’s weight as predetermined and fixed with my participants’ persistent weight management efforts, can perhaps be explained by looking at where the heavier moral burden of responsibility lies. Thorsby (2007), in a qualitative study which looked at how weight loss surgery patients accounted for their size, suggests that continued and persistent engagement in weight management for large individuals can perhaps be explained by the fact that it is the failure to “do something” (or be seen to do something) about one’s weight rather than the ‘fat’ body per se, that becomes the “site of moral censure” (2007: 1565).

### **8.5.1 Temporary shifts and abandoned body projects**

Notions of individual control were further complicated when women talked about weight management in pregnancy, where the heavy moral responsibility to “do

something” (Thorsby, 2007: 1565) about their weight and eating habits formed a central part of their accounts. In ways, these women’s accounts reflect current mothering literature, which has noted that pregnant women are routinely encouraged to enact ‘good’ mothering by controlling their eating and weight, to “ensure the production of ‘healthy’ babies” (Nash, 2013: 2; see also Markens et al., 1997; Lupton, 2011). Indeed it was clear from their accounts that women had internalised these discourses, as they described tacitly ‘knowing’ they had to eat well and manage their weight to ensure the health of the baby during pregnancy. In addition, most of my participants described being ‘unusually’ disciplined and stringent around what they were eating, above and beyond the typical remit for pregnant women to ‘watch’ what they were eating. This was particularly evident in the accounts of mothers who had children already, as they contrasted their experiences of their most recent pregnancy to past pregnancies, where, they indicated that, with respect to the latter, that they had typically taken ‘eating for two’ to the “extreme”. Interestingly, and perhaps as a result of this more intense focus on their eating and weight during their most recent pregnancy, many of the women in this study reported either losing weight or gaining minimal weight, that is less than they had anticipated, during this particular pregnancy. This is despite being identified as a group of women who were far *more* likely (than women of ‘normal’ weight) to gain in excess of the recommended gestational weight gain in pregnancy (Faucher and Barger, 2015).

The findings of this study suggest that for this particular group of women weight loss or minimal weight gain could, in part, be accounted for by concerns about the heightened risk their weight posed to the foetus, coupled with the intense surveillance, both self-imposed and that which was provided by the clinic, which



ensured that these women stringently managed their eating and weight during this period. Here we see resonance with Foucault's (1979) concepts of disciplinary power as respondents not only described the more obvious surveillance provided by the clinic, in the form of weigh-ins, more frequent foetal monitoring, more regular antenatal check-ups but also engaging in extensive self-surveillance. For example, participants with GDM described conscientiously monitoring their blood glucose levels at home and resisting the desire to eat certain foods (which they would have ordinarily eaten), such as cake and chocolate. Lupton (2012) has argued that the "liminality" and ambiguity between the "body boundaries" between the mother and the baby, is a dynamic, which in part, lends itself to heightened surveillance (2012: 333). This seemed to be further complicated and made more uncertain by the 'risk' which these large mothers (and their large bodies) purportedly posed to the unborn baby. This resultant clinical gaze emphasised the imperative to self-monitor, in an effort "to control and contain such ambiguity" (Lupton 2012: 333) and to protect the health of the foetus.

The extent and influence of the clinical 'gaze' experienced by these women during pregnancy was made all the more apparent when my participants described their transition to postpartum. It was here that their accounts highlighted yet again the importance of context and the temporary and transient nature of those shifts made to health behaviours during pregnancy. This was evidenced in Chapters 6 and 7, when my respondents suggested that in the absence of the 'tangible' risks associated with the foetus and surveillance provided by the clinic, that the impetus to maintain a healthy lifestyle had waned significantly. For example, a number of women described not having to 'think' about their eating as much in postpartum, which had

resulted in them ‘gobbling’ foods which they had restricted in pregnancy. Other studies too have reported similar findings; for example in a Swedish-based, qualitative study of first-time parents, Edvardsson and colleagues (2011) suggested that amongst their respondents “incentives for continuing a healthy lifestyle became weaker when the perceived health risks exposing the foetus were no longer present” (2011: 7). Indeed a number of my participants openly acknowledged ‘missing’ the intensive support and discipline provided by the clinic and admitted that, in the absence of such external ‘checks’, they had resumed their pre-pregnancy health-related behaviours and had begun to regain the weight lost in pregnancy. These findings are also congruent with those of other studies, such as Evans et al. (2010) who looked at health behaviours in postpartum amongst women with a history of GDM. Drawing on semi-structured interviews with 16 women, the authors reported that many of their respondents had felt “abandoned” by health professionals as they made the “quick transition” from their intensely medicalised and closely monitored pregnancy, to minimal or no follow up in postpartum. The authors suggested that, in the absence of support, changes made to health-related behaviours during pregnancy were not sustained into postpartum (or for any length of time), and further cautioned that the lack of follow up in postpartum could have the effect of potentially ‘downplaying’ future risk. I would argue that for the women in my study, this may also further explain the lack of engagement with risk in their conceptualisations of health seen in Chapter 5.

## **8.6 Social inequalities and weight management in postpartum**

For reasons outlined in Chapter 3, there were certain practical and ethical reasons which made class categories difficult, if not inappropriate to assign. Furthermore, given the exploratory nature of the research and the dearth of qualitative research in the area more generally, I felt that attempting to make class-based comparisons could have unduly narrowed and detracted from the wealth of possibilities and understandings generated by the data. This fact notwithstanding, my research does raise some interesting questions and possibilities for future research looking to deepen our understanding of the relationship between social class and weight management among large women in postpartum.

While strong associations have been documented between socio-economic status and the prevalence of obesity in the literature, there is little research looking at how women from different socio-economic backgrounds manage their weight. Moreover, there is a dearth of research looking at social class and how this might impact experiences and approaches to weight management amongst women who are already considered obese. Indeed, much of the existing research is limited and reports inconsistent findings (McLaren & Kuh, 2004). Among the general population research has suggested that women from wealthier backgrounds appear to be more concerned with their weight than women from lower socio-economic backgrounds (See Bourdieu, 1984; Paeratakul et al., 2002). In one UK base study Wardle and Griffith (2001), drawing on data from a nationally representative sample, found that women with higher socio economic backgrounds were more likely to consider themselves overweight and to diet, than women from lower socio-economic

backgrounds. Yet, other research has suggested that it is increasingly common to see that women of all backgrounds are concerned about weight management (Williams et al., 2011). In one study, which used data from the Australian Longitudinal Study on Women's Health, Williams et al. (2011) looked at the associations between social class and weight management from a sample of 11,589 women. The study showed that social class was not strongly associated with the desire to lose weight.

While I did not set out to draw comparisons between the individuals accordingly to such classifications, it is worth noting that although the women in this study came from diverse-socio cultural backgrounds, what is striking is the similarities of their accounts of health, body size and weight management. This was acutely apparent in my respondents conceptualisations of fatness, how they described their historical approaches to weight management (e.g. cyclical and fad diets), characterised their future plans to address their weight and the role they felt their weight played in their conceptualisations of their health. As addressed previously, the only striking difference appeared to be amongst first-time mothers, who were far more likely to express a desire to engage in weight management in postpartum 'for the baby' than the women in the study who had children already.

Moreover, as discussed previously, the women in this study tended to conceptualise their body weight and size as 'fixed', irreversible and as something beyond their immediate control, perceptions which appeared to have a significant influence on their overall approach to weight management. Future research might consider a comparative study, which purposively samples for large women from both lower and higher socio-economic backgrounds and look more closely at any interrelationship

between socioeconomic status and conceptions of health, body size and approaches to weight management.

Perhaps because this research explored experiences of weight management at a time when women reported being consumed by the demands of taking care of an infant (and often other children and family members), most reported being unable to prioritise their own needs (including weight management), with efforts to engage and/or sustain health behaviour change more often thwarted. As discussed in section 8.2 above, my participants' accounts seemed to reflect an instrumental conceptualisation of the body, imbricated with their mothering role. Again, this appeared to be a universal experience among the majority of women in the study regardless of their background. Although such assertions should be interpreted with caution, it does point to interesting avenues for further research. Again, future studies might consider employing a more comparative approach.

Overall, these findings tentatively suggest that for larger women, their socioeconomic status does not appear to overtly influence their feelings about weight, body size and the strategies to address it, in the first six months following childbirth.

### **8.7 Reflecting of the experiences of 'normal' weight women**

As highlighted in Chapter 2, much of the existing research looking at weight management in postpartum has focused almost exclusively on the experiences of women considered to be of 'normal' weight. Although this was not a study which explicitly set out to compare the experiences of large women with those of 'normal' weight, the findings of this study do hint (tangentially at least) at some interesting

similarities and possible differences between the experiences of large women and those of ‘normal’ weight women presented in the current literature.

One of the ways in which the findings of this study mirrors those from studies of ‘normal’ weight women, is that most of the women in this study expressed a desire to engage in weight management yet experienced notable challenges when attempting to enact health behaviour change. Although this study in many ways complicates the existing research by emphasising the inter-embodied aspects of the relationship with the mother and baby (and other family members) and its impact on engagements with health behavior change, akin to previous research it has pointed to the mothering role and the demands associated with taking care of an infant and other family members as something which has implications on women’s ability to prioritise their own health during postpartum (see Montgomery et al., 2013; Pill and Stott, 1982; Walker et al., 2004a; Warin et al., 2008). This appear to be experiences which are universal to women, independent of body size and weight.

As discussed previously, one of the most notable ways in which these findings differ from the current research is related to the notion of ‘bouncing back’ to pre-pregnancy weight and body shape. While previous studies have claimed that whether or not their bodies do ‘bounce back’ is a primary concern for women of ‘normal’ weight and this is assumed to be a universal experience (See Nash, 2015; Ogle et al. 2011 see also Bailey, 2001; Clark et al., 2009; Upton and Han, 2003), such concerns were notably absent from the accounts of the participants in this study. I have conjectured that one possible explanation is that many women in my study seemed to perceive their bodies as already ‘returned’, in light of the fact that most had lost or gained

minimal weight during pregnancy. Furthermore, this lack of saliency may also be understood when consider the many ways in which the women in this study seemed to be opting out of normative discourses about body size and weight. Again such observations certainly raise interesting questions which could be more fruitfully explored by a comparative study looking at the experiences of ‘normal’ weight women and large women.

## **8.8 Undertaking qualitative research**

By employing longitudinal qualitative methods in this study, it has been possible to explore the accounts offered by the same respondents at different points in time, thereby facilitating a more nuanced understanding of how individuals live and the factors that may (or may not) have influenced their engagements with health-related behaviours during postpartum. However, the analysis and interpretation of longitudinal qualitative data is complex, multidimensional and far from straightforward – the practicalities of which have not been well addressed in the literature (Holland, 2007). Indeed, apart from the difficulties I encountered when attempting to manage the sheer volume of the data generated by the interviews which I have addressed in Chapter 3, there were certain particularities to the interviews themselves which presented some unique challenges.

My analysis and interpretation were complicated by the fact that at times participants presented differing or contradictory versions of certain events. For example, when participants spoke about the genesis of their body size and weight, (which was a topic that tended to be discussed over several interviews), at times there were both notable and subtle changes to their accounts, as participants appeared to revise or

reinterpret the meaning of particular events or interactions. I drew upon William's (1984) work on 'narrative reconstruction' in an attempt to interpret these aspects of their accounts, but nevertheless it was not always immediately apparent how these conflicting accounts should be interpreted. As addressed earlier it is not beyond the bounds of possibility that the accounts changed because participants wanted to re-present or re-position themselves in a more favourable light.

Moreover, as Lewis (2007) points out, the 'unfolding' of individual stories over time are "not always told in a neatly linear way" (2007: 548). Again, I found that at times when participants were speaking about particular experiences in one interview, they often appeared to wait until a later interview to volunteer more detail. Lewis contends this is because

[P]eople forget things, they think they have already mentioned them, they prefer not to volunteer them until the relationship with the researcher has developed over several interviews, or something only becomes relevant in the context of later events. (Lewis, 2007: 548)

As the interviews tended to evolve in a non-linear fashion, it required that I also took these nuances into account. In this regard the interview summaries described in Chapter 3 were a useful (if not crucial) tool in organising and making sense of the interviews.

## **8.9 Limitations, implications and future directions**

In the final section of this thesis I reflect on both the practical and possible future research implications of my findings. Before going on to address those in more detail, I would like to begin by acknowledging and highlighting certain limitations of this research.



### **8.9.1 Study Limitations**

My findings might have been improved had I conducted a study which included both large women and women of ‘normal’ weight. This may have served as a useful comparison, to explore the issues which were connected with having a large body and those that might have been considered more universal experiences. Although I had given some consideration to this kind of sampling strategy initially, I felt that this would have created a sample size which was too big for this particular PhD.

The sample consisted of women who were recruited whilst attending a specialist antenatal metabolic clinic. As discussed in Chapter 3, a referral to the clinic was simply an ‘option’ to attend. As a cohort of women who had chosen to act upon this referral, it is possible that these women might have been more motivated to take part in a study investigating aspects of health and weight management, than women who had chosen not to attend the clinic. In turn, these women may have been a cohort who were more concerned about their health and, therefore, this may have impacted on how they spoke about aspects of their health and their plans for engagements in certain health-related behaviours. Finally, because these women were only recruited from one antenatal clinic, this limits the generalisability of the findings to the broader population, especially for large women who might not have had such a medicalised and intensely monitored experience of pregnancy.

As discussed in Chapter 3, although the longitudinal aspect of my research design allowed me to attempt to address certain gaps in the literature, it is also possible that interviewing the same person over time may have encouraged and at times even led participants to engage in certain behaviours and/or to present their accounts in a

particular way so as to position themselves in a more positive light. Although it could be argued that this is a possible limitation of any qualitative investigation, longitudinal or not, there were certain situations which arose which heightened my awareness to the likelihood that the interview or the prospect of future interviews might have influenced participants to engage in certain behaviours. For example, on one occasion when I returned to interview a participant, who had indicated in an earlier interview that they had planned to engage in health behaviour change, they described adopting those behaviours just a couple of days prior to our interview. Although I asked the participant at the time if they felt that the interviews or the knowledge that I was returning had the effect of influencing these types of behaviours, they indicated that it had not.

In spite of the limitations noted here, I have been able to gather a wealth of rich and nuanced data about people's understandings and experiences, which have notable practical and possible future research implications, which I will now go onto address.

### **8.9.2 Implications for policy and practice**

In this dissertation I have argued that my interviews provide a useful insight into the complexities around the engagements with health-related behaviours and weight management for large postpartum women and has several important implications for practice.

- As identified in Chapter 4 and in line with the findings of earlier research, there is strong evidence from this study to suggest that using terms like 'obese' may be considered offensive and alienating to some women. Findings from this study suggest that terms such as 'larger', 'bigger' and 'higher BMI'

are a preferable alternative.

- The findings of this study do raise interesting questions about how public health initiatives might go about engaging or perhaps (re-engaging) an audience who do not necessarily view their weight as a problem (Warin, 2011), and, on an experiential level, do not seem to experience their ‘fat’ bodies as posing a (future) health risk. The pejorative nature with which ‘fat’ bodies are viewed culturally and biomedically, and the overly simplistic framing of ‘fat’ as being equated with ‘poor’ or diminished health, would seem to have the effect of further alienating large individuals. In light of this, I suggest that a Health at Every Size (HAES) (Bacon and Aphramor, 2011) approach to public health initiatives be considered. HAES is a movement which discourages the assumption that all ‘thin’ people are healthy and, conversely, that all ‘fat’ individuals are unhealthy, instead endorsing the idea of promoting a healthy lifestyle for all. Tischner (2013) makes a similar point and suggests that a HAES approach “would mean that ‘large’ people will not automatically get constructed as health villains” (2013: 128).
- The transition from an intensely medicalised and closely monitored period in pregnancy to a period of minimal or no following up in postpartum would appear to have some notable implications for on-going engagements with health and weight management. Most of the women in this study recalled generally positive experiences of weight management during pregnancy (positive in the sense that they reported losing weight or gaining less than

anticipated) and, in this way, seemed to ‘benefit’ from the intensive observation provided by the clinic. Such findings would suggest that it is potentially problematic that these kinds of ‘supports’ are withdrawn as soon as women give birth. These findings would suggest that strong consideration could be given to putting in place support to assist women in continuing (and/or maintaining) health-behaviour change in the transition to postpartum.

- This research has highlighted several important issues relating to physical activity and sedentary behaviours. To begin with, as described in Chapter 7, participants in this study seemed to identify and conflate physical activity with exercise. In turn, exercise was almost exclusively engaged in when participants described ‘dieting’ and was reportedly rarely undertaken or maintained outside the parameters of weight loss. Because of the strong association of more vigorous forms of physical activity (such as exercises classes) with weight loss, some women were dismissive of the ‘value’ of engaging in less vigorous forms of physical activity. For example, some women questioned the ‘health’ benefits of becoming more physically active (such as going for a walk), in light of the fact that these were not activities which they perceived as promoting weight loss. The findings would suggest that public health initiatives should place emphasis on people becoming more physically active, rather than overtly focusing on weight loss (see previous comments on a HAES approach). Educating women about the health benefits, and about the calorie expenditure which can be achieved by walking, for

example, might be a useful strategy.

- The findings of this study indicated that women's receptivity to increasing their physical activity appeared to change over time. For example, when women in this study attempted to become more physically active, it was typically a feature of their accounts at three and six months, when their babies appeared to be in a more established routine of eating and sleep. Although the women in this study were largely unsuccessful in their attempts to become more physically active, nevertheless they appeared to be more receptive to the idea of increasing their physical activity at three to six months postpartum. Perhaps guidance related to physical activity, therefore, might be successful if initiated around three to six months postpartum.
- Mirroring the findings of recent quantitative studies (Durham et al., 2011; Evenson et al., 2013;) my findings suggest that women were spending large parts of the day being sedentary in postpartum. These findings are of concern given that others have identified long-term risks of high levels of sedentary time, independent of physical activity (Beunza et al., 2007; Healy et al., 2008; Thorp et al., 2010). Moreover current international guidelines for physical activity after pregnancy currently do not address sedentary behaviours at all (Evenson et al., 2014). The findings of this study would suggest that this needs to be addressed in future versions of the guidelines. The findings of this study also highlight the importance of encouraging women (particularly women who are breastfeeding) to try to become more physically active

throughout the day. This might be achieved (where possible) by encouraging women to stand or walk once they have become comfortable with breastfeeding or to intersperse these types of physical activities between feeds.

- Future recommendations regarding physical activity in postpartum should not only focus on physical activities outside of the home but also should offer recommendations for increasing physical activity with the knowledge that, for many of these women, a great deal of their day (at least during the first six months of postpartum) is likely to be spent in the home. These recommendations are in part reaffirmed by the findings of a recent qualitative study which explored the receptiveness of obese women to activity in the home ‘Maternal and Early Years Health Weight Service (MAEYS)’<sup>28</sup> (Atkinson et al., 2015). The researchers suggested that in particular the “convenience and comfort of home visits” was highlighted as one of the most significant advantages of the service, as having a young baby or older children were all cited as “barriers to attending appointments outside the home” (Atkinson et al., 2015: 3).

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<sup>28</sup> MAEYS is described as an innovative service, delivered by specialist healthy weight advisors (HWA), for obese women (BMI >30 kg/m<sup>2</sup>) during pregnancy and up to 2 years. The services are delivered by HWA’s who receive training to develop specific skills and competences in diet, physical activity, infant feeding and behaviour change. The service focuses on healthy gestational weight gain, postpartum weight loss and establishing healthy infant feeding and active play. The service is free and delivered on a one to one basis, in the woman’s home (see Atkinson et al., 2015).

- An inter-embodied approach to health at this particular point in the life course may allow for more nuanced discussions around health and weight management during postpartum. In particular, it seems that as the bodies of the mother and infant are so entwined, public health initiatives should encourage and promote physical activities which can be engaged in *with* children, rather than activities which would be pursued alone. This might be as simple as health practitioners raising awareness with mothers (or mothers to be) about some of the unforeseen challenges they are likely to encounter when attempting to plan regular physical activity outside of the home and away from their children in postpartum. Public health initiatives might consider targeting funding at encouraging walking based activities (such as pram pushing) which can be more easily engaged with children. Moreover, policy makers might consider targeting funding at and/or supplementing short-term child-minding and crèche facilities at leisure centres and gyms etc. so that mothers might more easily engage with and become more physically active during postpartum.
- Consideration should be given to public health initiatives which encourage ‘on demand feeding’ (NHS Choices, 2015), particularly in light of the fact that large women do not feel comfortable breastfeeding in public. In the drive to encourage women to breastfeed, we see a public health initiative which fails to incorporate both the broader cultural meanings attached to the breast, and for some of these women, overlooks the discomfort around exposing the large body, which was positioned as an unavoidable aspect of attempting to

breastfeed in public. If we consider both the practicalities of breastfeeding in concert with initiatives that encourage ‘on demand feeding’, this could be seen to create constraints around the mother’s ability to pursue physical activities outside of the home. One possible solution to this problem would be to encourage ‘mixed feeding’ or ‘combination feeding’, in which the baby receives both breast milk and formula, which would, in theory, afford breastfeeding mothers more of an opportunity to leave the home and engage in physical activity.

### **8.9.3 Implications for future research**

In the following I highlight some possible future directions, which could be taken by researchers wishing to look at weight management and health among large women in postpartum.

- This study has highlighted the importance of looking at the embodied aspects of the accounts of mothers and care work. I echo Doucet’s (2013) call for researchers to “rethink how we conceptualise care” and the “embodied relations between parents and children” (2013: 300). As I have suggested, this is of critical importance if we are to gain a better understanding of the complexities of engagements with health and weight management at this particular point in the life course. In addition, I would argue that future research in the area of mothering needs to adopt a more nuanced notion of inter-embodiment and move beyond the explicit focus on the mother and the infant, to consider how other bodies, particularly those living within the same



household, impact weight management activities. Therefore future research in the area might consider more explicitly incorporating the views/bodies of other people e.g. by interviewing partners and/or conducting observations within the household to capture these kinds of inter-embodied dynamics more fully.

- Although I did not specifically design this study to explore differences between first-time mothers and mothers with children already, some of the findings of this research hints at notable gaps between these groups of mothers, which are worthy of further exploration. A comparative study between these two groups of mothers could provide important insights into the ways in which the transition to first-time motherhood might affect individuals and health behaviours in different and complex ways.
- The findings of this study suggest that following women for a more extensive period may yield more fruitful results with regard to health behaviour change. For example, how these women went about engaging with weight management during pregnancy had a notable impact for weight management in the postpartum period and therefore it would be interesting to follow women as they made this transition, rather than rely on retrospective accounts. Additionally, although certain time limitations posed by the PhD prevented me from following these women beyond six months, future research might consider doing so. As discussed in Chapter 7, it was typically in the latter stages of the study period, when the baby appeared to be in a

more established routine that women reported attempting to actively engage in health-behaviour change. Although, their accounts reflected largely unsuccessful attempts, it is conceivable that they may have been more successful in the future or equally that the lack of success initially may have discouraged further efforts at health-behaviour change. In addition it would be interesting to explore how other factors such as the return to work affect engagements with health-related behaviours.

- My findings suggest that there may be additional (and unforeseen) restrictions and perhaps a reluctance on the part of women recovering from caesarean birth, to engage in physical activity during postpartum. Given the high rates of caesarean birth amongst large women (Heslehurst, 2008; Leddy et al., 2008; Ovesen, 2011), and with recovery complications more commonly reported in those who are morbidly obese (NICE, 2008; Yeeles et al., 2014), I would suggest that this is an area of research which warrants further exploration.

## **8.10 Final reflections**

This thesis adds to the dearth of research looking at engagements with health and weight management in the first six months of postpartum, particularly for large women. At a time when increasing attention is being paid to the risks related to maternal obesity, large women are increasingly positioned as being in need of intense “medical and health scrutiny because of the maternal and childbearing risks that being overweight presents” (Unnithan-Kunar, 2011: 2). For a group of large women

who did indeed experience an intensely medicalised pregnancy, this study has highlighted some of the unforeseen consequences of a transition from a highly monitored and controlled pregnancy to a period with minimal or no support, which had significant implications for health and weight management.

The longitudinal aspect of the study design clearly demonstrated that, although there may be a desire among women to engage in health behaviour change in postpartum, the idea of postpartum as a ‘window of opportunity’, is complicated. The findings of this study suggest that despite the expressed intention to make health behaviour change, which on first glance would appear to concur with these assertions, certain historical, embodied and inter-embodied realities conspire, resulting in complexities around the possibility of successful health behaviour change.

As I have shown throughout the findings and this discussion, health and weight management for this particular group of women seemed very much ‘grounded’ in the present. As highlighted earlier, it was my participants’ present state of embodiment which appeared to define their approach to health and, accordingly, in the absence of illness or struggle to get through the day, most participants articulated that they were unlikely to take preventative steps to manage or improve their future health risk. Furthermore, my participants generally indicated that that they felt they were genetically predisposed to being large and also seemed to imply a certain intransience and permanence to their weight, which conceivably reinforced this resistance to change. The inter-embodied relationship with the infant, in which the agency of the mother was described as becoming entwined with the body of the infant, again seemed to have the effect of ‘grounding’ health and weight management

in the present. Not only did my participants describe being consumed by the very practical demands of taking care of an infant (and other family members), they also appeared to be restricted by the ideologies of ‘good’ mothering as they positioned themselves and their health in highly sacrificial ways, which they suggested made it difficult for them to prioritise their own needs. Again this is a dynamic which emphasises a focus on the present rather than change.

Finally, this thesis has demonstrated the utility and necessity of looking at postpartum through an inter-embodied lens. Through my analysis of the experiences of large women over time, I have shown that inter-embodiment is a concept with the potential to offer a much more nuanced understanding of engagements with weight management and health-related behaviours at this particular point in the life course. In doing so I have also extended previous use of the concept in the area of mothering research. Examining postpartum with a focus on the lived and embodied experiences, allows us to begin to (re)conceptualise public health interventions in ways which accommodate and reflect the lived reality of people’s daily lives, thus having the potential to be more successful.

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## **Appendices**

### **Appendix 1: Participant Invitation Letter**

#### **Women's experiences of weight management and health following childbirth – A qualitative study**



Centre for Population Health Sciences  
Medical School  
Teviot Place  
Edinburgh EH8 9AG

#### **Participant Invitation**

I am a PhD student at the University of Edinburgh and would like to invite you to take part in an interview study, looking at women's lives, attitudes towards health and experiences of weight management in the 6 months after childbirth. To do this, I would need to interview you at six weeks, three months and six months following childbirth.

This study is being done to develop a better understanding of the issues and challenges for women after giving birth to a child. The findings will be used to identify better ways to support women in the future as they manage their weight and health following childbirth. I have enclosed an information sheet giving you more details about the study and an opt-in form should you decide to take part.

Thank you for reading this letter and thinking about taking part in the study.

Yours sincerely,

**Suzanne Connolly (PhD Student)**

## **Appendix 2: Participant Information Sheet**

### **Women's experiences of weight management and health following childbirth – A qualitative study**



#### **Participant information sheet**

I am a PhD student at the University of Edinburgh. I would like to invite you to take part in an interview study looking at women's lives, attitudes towards health, experiences of weight management and how these may change in the six months following childbirth. Before you decide whether to take part in this study, it is important that you understand why it is being done and what it will involve. Please take the time to read the following information carefully and discuss it with friends and family if you wish. Please contact me if anything is not clear, or if you would like more information. Contact information is provided on page 3 of this information sheet.

#### **What is the purpose of the research?**

This study aims to understand women's everyday lives, attitudes towards health and experiences of weight management in the six months after childbirth. This period can be busy time for women, which is full of change and new experiences. As a researcher, I would like to learn more about your experiences and views, so that I can help to identify the best ways to support women and improve services to help them manage their weight and health after childbirth.

#### **Why have I been invited?**

You have been invited because you are or have attended the antenatal metabolic clinic or postpartum follow-up clinic at the Royal Infirmary at Edinburgh and have recently, or will shortly, give birth.

#### **What would taking part in the research involve?**

If you decide to take part you will be interviewed three times. The first interview will take place around six weeks after childbirth, the second at three months and the final interview at six months after childbirth. You will be able choose the date and time of your interviews and also where you would like to be interviewed (in your home or other suitable location). With your permission, I will record your interview. If you do not want your interview to be recorded, I will take notes instead. Your interviews will each probably last around 1 hour, although this would depend on what you have

to say. You will also be given a copy of this information sheet and, if you choose to participate, a signed consent form for you to keep.

**Do I have to take part in the research?**

No. Taking part in this interview research is entirely up to you and your decision will not affect your medical care in any way. If you decide you would like to be interviewed, you will be given this information sheet to keep. You will also be asked to sign a consent form. You will be given a copy of this consent form and we will also keep a copy. You will be free to stop your interview at any point without giving a reason.

**Will my taking part in the research be kept confidential?**

Yes. All information that is collected about you during the study will be kept strictly confidential and will be stored in a locked filing cabinet or on a password-protected computer within a locked office at the University of Edinburgh. This information will not be made available to anyone apart from the researcher. With your permission, the recording of your interview will be typed up. When it is typed up, any names, details or other information which could possibly identify you will be removed or changed. When I write up the study's findings I will also make sure that it will not be possible to identify you from any of these findings. All files will be disposed of after completion of the research.

**What will happen to the results of the research?**

The results will be used as part of a PhD thesis. I also hope to publish the findings in scientific and policy journals and present them to health professionals, voluntary organisations and groups involved in the care of women following childbirth. The results will be used to help to improve the information and support offered to women trying to manage their weight and health after childbirth.

**Are there any benefits to taking part in the research?**

You will receive a £20 gift voucher from a store of your choice, at the end of the third interview. I also hope that you find the research an interesting experience. Taking part will help to support and improve services for women following childbirth.

**Are there any disadvantages to taking part in the research?**

It is anticipated that each interview (there are 3 in total) will take approximately 60 minutes of your time, depending on what you might have to say.

**Will it cost me any money?**

No, there will be no cost to yourself. If you need to travel to attend your interview, I can cover your costs.



**Who has reviewed the research?**

The research has been approved the NHS Lothian, South East Scotland Research Ethics Committee.

**If I want to take part, what will happen next?**

If you are willing to take part in an interview, please complete and return the opt-in form using the stamped-addressed envelope provided in this recruitment pack. If you are selected for an interview, Suzanne will contact you to explain what the research is about, to answer any questions you might have, and to arrange a time for your first interview.

At the start of the first interview Suzanne will ask you to sign a consent form. By signing this form, you show that you fully understand what this study is about and that you are happy participate.

**Contacts for further information**

If you would like more information or want to ask any questions about this research, then please contact me. My contact details are as follows:

**Suzanne Connolly**

**Centre for Population Health Sciences**

**University of Edinburgh**

**Medical School**

**Teviot Place**

**Edinburgh EH8 9AG**

**Tel: 0131 650 3225**

**Email: [s.g.connolly@sms.ed.ac.uk](mailto:s.g.connolly@sms.ed.ac.uk)**

If you would like to speak to an independent person who is not involved in the study to seek general advice about taking part in research, or have concerns about this study that you wish to raise, please contact:

**Dr Sarah Wild**

**Reader in Epidemiology and Public Health  
and Honorary Consultant in Public Health**

**The University of Edinburgh**

**Medical School**

**Teviot Place**

**Edinburgh EH8 9AG**

**Tel: 0131 651 1630**

**Email: [Sarah.Wild@ed.ac.uk](mailto:Sarah.Wild@ed.ac.uk)**

If you wish to make a complaint about the study please contact NHS Lothian:

**NHS Lothian Complaints Team**

**2nd Floor**

**Waverley Gate**

**2-4 Waterloo Place**

**Edinburgh EH1 3EG**

**Tel: 0131 465 5708**

Thank you for taking the time to read this information sheet.

## Appendix 3: Participant Opt-In Form

### Women's experiences of weight management and health following childbirth – A qualitative study



#### Opt-in form

Thank you for taking the time to read the participant information sheet. **If you would like to take part in the study please complete this form and return it in the stamped-addressed envelope provided.**

Name: [Please print]

\_\_\_\_\_

Postal Code: \_\_\_\_\_

Anticipated Due Date/ Actual Delivery Date: \_\_\_\_\_

Contact details: Telephone – day time: \_\_\_\_\_

Telephone – evening: \_\_\_\_\_

Telephone – mobile: \_\_\_\_\_

Email address: \_\_\_\_\_

Preferred time to call: \_\_\_\_\_

After returning this form you will be contacted by Suzanne Connolly who is the researcher on the project. In the meantime, if you would like further information or have any questions about the study then please feel free to get in touch with Suzanne using the following contact details:

Suzanne Connolly  
Centre for Population Health Sciences  
University of Edinburgh  
Teviot Place  
Edinburgh EH8 9AG  
Tel: 0131 650 3225  
Email: [s.g.connolly@sms.ed.ac.uk](mailto:s.g.connolly@sms.ed.ac.uk)

## Appendix 4: Participant Consent Form

### Women's experiences of weight management and health following childbirth – A qualitative study



#### INFORMED CONSENT for interview stud

Participant identification number: ..... [researcher to complete]

Thank you for reading the information sheet about the study. Please initial the boxes below to confirm that you agree with each statement:

1. I confirm that I have read the participant information sheet dated 26/06/12 (version 1.0) for the above study. I have had the opportunity to ask questions and I am satisfied with the answers I received. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, without my medical care legal rights being affected. ☐
3. I understand that this project have been reviewed by, and receive ethics clearance through, the University of Edinburgh School of Health in Social Science Research and Research Ethics Committee and NHS Lothian, South East Scotland Research Ethics Committee. ☐
4. I am willing to have my interview audio-recorded and understand that this recording will be typed up. ☐
5. I understand and agree to the use of anonymised quotes in publications, reports and other research outputs. ☐
6. I understand who will have access to the data provided, how the data will be stored, and what will happen to the data at the end of the project ☐
7. I agree to participate in the study. ☐

**Name of participant**

**Signature**

**Date**

**Person taking consent**

**Signature**

**Date**

## **Appendix 5: Interview Topic Guide**

### **Interview Topic Guide**

#### **Personal and Demographic Information of Respondent:**

Can you tell me a little bit about yourself?

- What is your age? What is your ethnic group? What is your marital status? Who do you live with? Do you work? If you work, what is your occupation? If you work, do you plan to return to work? If yes, when? What is your highest level of education? What is your partner's employment status and occupation? What is your partner's highest level of education? What are the gender and ages of any other children in the house?

#### **Pregnancy Experience:**

##### **FIRST INTERVIEW**

- Is this your first pregnancy? Describe your experience of being pregnant? Is it any different from previous pregnancies? Did the pregnancy go as planned? Complications? What was your experience of attending a specialist antenatal clinic? How do you think your life have changed pre-and post-pregnancy? Expectations versus reality?

FOLLOW UP INTERVIEW: Has it changed since the last interview, how/why?

#### **Domestic Arrangements:**

- Who else apart from yourself, is involved in such things as childcare, food preparation and household management? Describe a typical day? Describe your childcare arrangements?

FOLLOW UP INTERVIEW: have there been any changes in your domestic and personal circumstances since the last interview? Has this affected food preparation and the types of food eaten, exercise habits etc.?

#### **Built Environment:**

- How long have you lived here? What is it like to live in this neighborhood? Do you feel safe? Is it easy to walk around? Do you use public transport? Is it easily accessible? Are there places to exercise nearby, parks etc? Accessibility of shops for food purchases; Do you buy your food at a local supermarket? Where else do you get food, etc? Food quality?

#### **Health/ Body and Weight Management:**

- Do you feel healthy? Describe what feeling healthy means to you and what is its relevance in your life at the moment; How do feel about your body at the moment? Your current weight? Are you doing something to manage your weight presently? If so, describe what you do? Did you receive advice regarding diet and exercise from any particular source during pregnancy/postpartum (medical professional, family member, friend, literature)? Do you have any historical experiences of weight management/attempting to lose weight? Do you feel these experiences have shaped and influenced your present motivations in anyway? Experiences/observations of body shapes/ weight gain in others?

FOLLOW UP INTERVIEW: Has you ability to manage your weight/ motivation to do so, changed since the last interview, how/why?

#### **Food/Eating:**

- What are you currently feeding yourself, your baby, and other family members? Are you mostly responsible for meals? Do you cook? What factors and considerations influence and inform your current food and eating practices? Describe what 'healthy foods' mean to you? How have your eating habits changed from past practices, pre-pregnancy, post or since the last interview?

#### **Physical Activity:**

- What activities do you like doing/ why? (hobbies, exercise, community, clubs and groups). Please tell me the type(s) of physical activities that you did/do? Of these physical activities you just told me about, which is the one you do the most? Which of these activities are with friends, relatives, etc.? Are you physically active at home or at work (e.g., carrying laundry, walking up stairs, physical labor for work like walking, lifting, and building)? What stops you from doing more of the activities that you enjoy? How important is getting daily

physical activity for you? What motivates you or would motivate you to be physically active? What makes it hard for you to be physically active?

**Breastfeeding:**

- Are you breastfeeding presently? What factors influence this decision? If yes, how long do you plan to breastfeed? How would you describe the experience of breastfeeding?

**Any Other Issues:**

- Are there any issues that you would like to raise that you feel haven't been touched upon elsewhere in the interview?



## Appendix 6: NHS Lothian Favourable Opinion Letter

### Lothian NHS Board

### South East Scotland Research Ethics Committee 01



Waverley Gate  
2-4 Waterloo Place  
Edinburgh  
EH1 3EG  
Telephone 0131 536 9000  
Fax 0131 465 5789

[www.nhslothian.scot.nhs.uk](http://www.nhslothian.scot.nhs.uk)

Miss Suzanne Connolly  
Centre for Population Health Sciences  
Medical School, Teviot Place  
Edinburgh  
EH8 9AG

Date 15 August 2012  
Your Ref  
Our Ref

Enquiries to: Sandra Wyllie  
Extension: 35679  
Direct Line: 0131 465 5679  
Email: [Sandra.Wyllie@nhslothian.scot.nhs.uk](mailto:Sandra.Wyllie@nhslothian.scot.nhs.uk)

Dear Miss Connolly

**Study title:** PERCEPTIONS AND EXPERIENCES OF THE BODY,  
WEIGHT & ENGAGEMENTS WITH HEALTH-RELATED  
BEHAVIOURS FOLLOWING CHILDBIRTH - A Qualitative  
Investigation of Women who Attended a Specialist  
Antenatal Metabolic Clinic in Scotland  
**REC reference:** 12/SS/0131  
**Protocol number:** n/a

Thank you for your letter of 13 August 2012, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

### Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.



Headquarters  
Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Chair Dr Charles J Winstanley  
Interim Chief Executive Tim Davison  
*Lothian NHS Board is the common name of Lothian Health Board*

The Sub Committee made the following additional comments:

- The tone of how potential participants will be approached is not quite appropriate. They suggested the text could be amended to: "potential participants may be approached and asked if they would like to participate"
- Please add serious illness in the baby (not just death) as exclusion.
- Please note that this Committee is SESREC1 and over 16 is the legal Scottish definition of adulthood.
- Please correct the typo in the letter of invitation.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

**You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation.**

#### **Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Response to Request for Further Information: Amendments detailed.	Version 1	13 August 2012
Letter of invitation to participant	Version 2	13 August 2012
Other: Participant opt in form	Version 1	26 June 2012
Other: Participant Interview Topic Guide	Version 1	26 June 2012
Other: CV Chief Investigator (Connolly)		
Other: CV Supervisor (Lawton)		
Other: GP letter	Version 1	13 August 2012
Participant Consent Form	Version 2	13 August 2012

Participant Information Sheet	Version 2	13 August 2012
Protocol	Version 2	13 August 2012
REC application		24 July 2012

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

#### After ethical review

##### Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

##### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/SS/0131	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project

Yours sincerely



**Dr Janet Andrews**  
Chair

Email: Sandra.Wyllie@nhslothian.scot.nhs.uk

*Enclosures:* *List of names and professions of members who were present at the meeting and those who submitted written comments.*

*"After ethical review – guidance for researchers"*

*Copy to:* *Marianne Laird*  
*Karen Maitland, NHS Lothian*

# **South East Scotland Research Ethics Committee 01**

## **Attendance at Sub-Committee of the REC**

### **Committee Members:**

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Janet Andrews	Associate Specialist	Yes	
Mr Lindsay Murray	Health & Safety Manager	Yes	

### **Also in attendance:**

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Sandra Wyllie	Committee Co-ordinator

## **Appendix 7: Participant portraits**

**Susan:** Susan is a 33 year old, single mother of one. At the time of the interviews she lived alone in a modest two bedroom flat in a village on the outskirts of Edinburgh. She has a university degree and now works in a full-time, permanent position in the IT industry. This is her first child and she gave birth by planned c-section due to complications resulting from a bicornuate uterus, which was identified early on in the pregnancy. She described the pregnancy as unplanned and a 'complete shock'. The father of her baby has no involvement in her son's life. She relies heavily on the support of her parents, who live nearby, for child minding etc. She intends to resume full-time employment at the end of her maternity leave.

**Sarah:** Sarah is 25 years old. She is the mother of two children, a six-week old baby girl and her five year old son, from a previous relationship. At the time of the interviews she lived in a council flat with her two children. The baby's father does not live there permanently, but by her own admission, was around a lot more as he was currently out of work and on disability. At the time of the final interview she indicated that they were no longer together and that he had moved out but that he was providing some financial support and helping her with child minding etc. She has a high-school diploma and is long-term unemployed. She indicated that she had no plans to seek employment outside of the home until both children were attending school full-time.

**Lisa:** Lisa is 31 years old, married with one child. Lisa has a university degree and prior to her maternity leave, she was a full-time student, having returned to university to pursue a degree in the arts. She also works part-time in retail to 'help pay the bills'. She lives with her husband, who works full-time as an IT consultant. They own their own home.

**Mel:** Mel is 35 years old and is originally from North America. Mel has a university degree but in the year prior to her most recent pregnancy she returned to university part-time with a view to retraining as an allied health professional. She plans to resume her studies once her daughter is weaned - which she plans to coincide with the beginning of the academic year. She is married with two older children, four and seven years old. Her husband works in business and travels a lot during the week. They live in a large flat which they rent in central Edinburgh.

**Jane:** Jane is 30 years old and the mother of four children. She is married and lives in a council flat in a housing estate on the outskirts of Edinburgh. At the time of the interviews, she and her husband were in the process of negotiating with the council to move to a bigger place - a house with a garden. Her husband is self-employed and works in the trades. She worked full-time at a bookies prior to her maternity leave, however she has no immediate plans to return to work. She is currently exploring her options and would like to go back to school and qualify as a mid-wife but is unsure how she would balance her studies while taking care of her four children.

**Bernie:** Bernie is 41 years old and the mother of three children. She is married and lives in her own home in a small housing estate near Edinburgh. Her husband works

full-time as a manager in a manufacturing company. She has a university degree but never worked in the area which she qualified in. She has worked for many years in the medical field as an administrator. She has taken maternity leave for a year and then plans to return to work part-time. Once her youngest is in school, she will resume full-time employment. She described her recent pregnancy as unexpected and confided that both her husband had assumed that they were 'finished having children'.

**Salma:** Salma is 21 years old and the youngest study participant. She is originally from Pakistan and her family immigrated to Scotland when she was 12 years old. She is married but her husband currently lives in Pakistan and has failed to secure a visa to travel to the UK – this is a situation that she did not foresee changing in the immediate future. She lives in a large family home with her grand parents, mother, sister, brother and his wife. After graduating high-school she worked as a carer and most recently in a number of different sales positions. She was unsure when she would return to work and indicated that she would like to apply to university to study medicine in the future. Although her immediate family were on hand to help with the baby, she indicated that she found it very challenging without the assistance of her husband.

**Tara:** Tara is 26 years old and the mother of two children, her six-week old baby and her nine year old daughter from a previous marriage. She is not currently in a relationship and the baby's father resides overseas and is not actively involved in rearing the baby. Tara graduated from high school and is a full time carer for her ex-husband, who is retired on medical grounds. She lives in a council house and moved to what she described as a better neighborhood during the course of our interviews together. Although she is single, her ex-husband is helping her to raise both children and was often on hand to assist with night feeds, baby-sitting, share meals etc.

**Liz:** Liz is 31 years old, married with two children. She and her husband have recently sold their house and are in the process of buying a house which is closer to Liz's work. Liz is qualified as a teacher and had recently been promoted to school administration. Her husband works full-time in emergency services, with shifts that alter weekly. Liz indicated that her husband's changing work schedule often makes child-care and maintaining day-to-day routines very challenging. Liz plans to return to full-time employment at the end of her maternity leave.

**Alice:** Alice is 28 years old, married and is the mother of one. She lives with her husband in their own home, in a housing estate in Edinburgh. She has a HND in health care and works providing specialized health care for children with significant health issues. Her husband works full-time in the trades. Alice has no immediate plans to return to work as she and her husband plan on having more children in the not too distant future.

**Harjeet:** Harjeet is 31 years old, married with three children. She and her husband live in their own home in a small affluent town outside of Edinburgh. She and her husband are 2<sup>nd</sup> generation Indian and practicing Hindu's. Harjeet has a large extended family who also live in the area. Harjeet works full-time in the tourist industry and plans to return to her job at the end of her maternity leave. She indicated

that financially it was not an imperative that she return to work but that she felt for her own 'sanity' it was a necessity. Harjeet's husband works full time as a manager for a large retail company.

**Caroline:** Caroline is 32 years old, engaged to be married and cohabitates with her fiancé in a rented flat in a new housing estate close to Edinburgh. Her fiancé is self-employed and works in the trades. Caroline has a university degree but after about a year of working in her field, she left the position as she felt it 'wasn't a good fit'. Prior to taking maternity leave she worked for many years as a manager in a betting shop. She had planned to take six months maternity leave but was forced to return to work due to financial reasons when her son was about four months old.

**Emily:** Emily is 33 years old, married and the mother of one. She owns her own home, a tenement flat in central Edinburgh where she lives with her husband. Her husband is employed full-time and works in management. Emily has decided to take a years maternity leave, after which she will return to her job in the civil service, where just prior to becoming pregnant she had been promoted to a more senior position.

**Alison:** Alison is 33 years old, married, with five children. She lives with her husband and children in a semi-detached house which they own, in an estate in a large town outside Edinburgh. She works full-time for the postal service and plans return to work after nine months of maternity leave. Her husband works full-time for the council.

**Donna:** Donna is 29 years old, married with one child. She lives with her husband in a tenement flat which they own. Donna's husband works full-time as a service technician for an IT company. Donna completed high school and currently works for as a manager for a retail company in Edinburgh. She plans to return to her position full-time after her maternity leave.